

**The Acute Medical Unit: Narratives of
older people and their informal carers
about the hospital stay and
resettlement experience**

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Abstract

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Introduction

Many older people presenting to Acute Medical Units (AMUs) are discharged home after only a short length of stay, yet research has found that many re-present to hospital within a year. This constructivist study explored patient and informal carer views of care and treatment received on an AMU whilst participating in a trial of a specialist geriatric intervention.

Method

Eighteen older patients and six of their informal carers were purposefully selected from the above trial. These participants were interviewed in their homes up to six weeks following discharge. An interview guide was used to encourage participants to provide both narratives and their opinions and views around the AMU stay, and the resettlement period back home. The data were analysed using two analytic approaches: thematic and narrative analysis.

Results

The analysis revealed five major themes. These revolved around participants making positive comments about the AMU staff, whilst also revealing an underlying subtle message that things could be better. The participants were similarly positive about the geriatricians, but were unable to articulate what had been done for them. On discharge, the patients had both outstanding health and daily living needs, which were not resolved by the admission. These needs impacted on their informal carers, who supported them with their daily living activities. Overall these participants were stoical and had low expectations of hospital care.

Conclusion

The study has provided an in-depth understanding of the older patient and informal carer experience of an AMU stay. The recommendations made revolve around meeting patient's basic physiological needs, improving staff communication with both patients and their informal carers, and improving the on-going care management of these patients post discharge, including further medical review and rehabilitation.

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Chapter One

Introduction

Background to the Research

In the United Kingdom (UK) hospitals are facing a growing crisis as they try to reconcile an inexorable rise in demand for hospital beds coupled with a shortage of available beds. At a time when there is increased demand on acute healthcare services, many acute hospitals are feeling the impact of a reduction in acute bed capacity, leading to a constant battle between the need to balance demand and capacity (Robinson et al 2014). The total number of beds available in hospitals in England fell from 282,918 in 1988-1989 to 136,486 in April 2013 (Campbell 2013). Emergency departments are the 'front line' of the National Health Service (NHS) and the increasing demand for acute care is taking its toll in these departments. This is evidenced by the fact that the NHS experienced its first ever emergency department crisis in the summer months of 2013, when the usual winter crisis of bed shortages impacted on emergency departments in the summer (Campbell 2013). Warnings have been raised that emergency departments are on the brink of collapse, and some senior doctors have likened the overcrowding in these departments to 'war zones' (Mason 2013). David Cameron, the Prime Minister, has attributed the increasing crisis in the NHS to the one million extra people visiting emergency departments compared with three years previously (Mason 2013). This rise in emergency numbers has further contributed to the shortage of hospital beds, with elective admissions cancelled to accommodate unplanned admissions (Matthews 2012).

Doctors in emergency departments are under pressure to quickly assess and treat an unpredictable case load of acutely ill patients. This pressure has been intensified by the Department of Health (DH) 'four hour' target for emergency care (DH 2000a). This target came into force in 2004 as a result of patient dissatisfaction around waiting several hours in the emergency departments for assessment, diagnostic tests or a hospital bed. The target requires that patients should be seen, and then admitted, transferred or discharged within four hours of arrival at the department. The aim of the target is to improve patient satisfaction

and care in the emergency departments. Government evaluations of this target have shown improved waiting times in the emergency departments. However it has been argued that the target has created problems both 'downstream', with patients 'stacked' in ambulances, waiting outside emergency departments, and 'upstream', where the pressure for rapid assessments has led to incomplete assessments and inappropriate admissions (Munir 2008).

Admitting patients from the emergency department is frequently problematic given the bed crisis being experienced in acute hospitals. The alternative is to discharge patients home. However, if patients are discharged home prematurely, there is a risk of them re-presenting at the emergency department. As many as 35,000 patients a month (one in 13) have been recorded as returning to the emergency department within a week of their initial visit (Ramesh 2011). The rise in acute re-admission rates has become a political issue with the government initiative of non-payment of treatment costs for patients re-admitted within thirty days of discharge. This initiative emphasises the need for patients to be discharged home appropriately the first time around (Robinson et al 2014).

One innovation to help the NHS to cope with the rise in emergency department numbers combined with a reduction in the number of acute hospital beds has been the establishment of Acute Medical Units (AMUs) (Scott et al 2009, Van der Linden et al 2010). The Royal College of Physicians has repeatedly stressed the importance of establishing AMUs within acute care hospitals (St Noble et al 2008). This is in response to the recognition that medical admissions are continuing to rise, and to concerns around the subsequent quality of care provided by the acute medical services. A recent survey of acute NHS secondary care Trusts in England, Wales and Northern Ireland revealed that as many as 98% of the hospitals in these Trusts now have AMUs (Percival et al 2010).

AMUs are known by various names across different hospital trusts, including Acute Assessment Unit (AAU), Acute Admissions Unit (AAU), Clinical Decision Unit (CDU), Emergency Assessment Unit (EAU), Emergency Medical Assessment Unit (EMAU), Medical Assessment and Planning Unit (MAPU), Medical Assessment Unit (MAU), Multi-Speciality Assessment Area (MSAA), Medical Receiving Unit (MRU) and Emergency Receiving Unit (ERU). Regardless of the terminology

employed these units are united by their function to receive medical patients presenting with an acute illness from either the emergency department or directly from general practitioners. Standards for AMUs stipulate that these units should be staffed by medical staff (both senior and junior doctors) together with a multi skill mix of nursing staff, and allied health staff (speech and language, physiotherapy and occupational therapy) (Henley et al 2006). Despite being part of the emergency care pathway, AMUs more closely resemble inpatient wards. So, for example, there are set visiting hours, ward rounds, medication rounds, and set meal times (Lees & Chadha 2011). The aim of these units is to facilitate efficient emergency admissions and to reduce the length of hospital stays. Once on the AMU patients are assessed and treated over a short designated period (typically under 72 hours), and then either discharged directly home or transferred to a medical ward (Scott et al 2009). Importantly once on the AMU, 'the clock stops' for those patients received from the emergency department, thus preventing a breach of the emergency department four hour target.

It has been argued that AMUs provide a means of responding safely and efficiently to the complex demands being placed on the acute care system. There is evidence in the literature to suggest that AMUs decrease both patient admissions and the average length of patient stay (Scott et al 2009). Conversely it has been suggested that AMUs are purely 'holding bays' to prevent potential breaches of the four hour target, and particularly disadvantage older people who present to the emergency department with multiple rather than single conditions (Munir 2008).

The older population represents the highest consumers of AMUs as they more commonly present to the emergency department than the younger population (Aminzadeh & Dalziel 2002, Caplan et al 1998, Hastings & Heflin 2005, Munir 2008). Older people are also at greatest risk of re-admission after being discharged home from emergency departments (Munir 2008). One study found that as many as 17% of patients aged 75 years and over, discharged from the emergency department were admitted to hospital within a month of being sent home (Caplan et al 1998). Older people have more complex health needs, as they often present with co-existent medical, functional, psychological and social needs (Ellis et al 2011). Their illness presentation is often non-specific and can be accompanied by cognitive decline and/or functional deterioration. These patients often have not just

multiple co-morbidities but also multiple medication needs. The needs of older people are thus complex and their assessment with intervention requires longer than the younger population. These needs can be challenging for junior doctors to identify and address while working in the fast pace of acute medical care (Conroy & Cooper 2010, Hendriksen & Harrison 2001).

It is recognised that many physicians and junior doctors working in acute medicine are not trained either in geriatric medicine or in identifying functional needs (Conroy & Cooper 2010, Hendriksen & Harrison 2001), yet it falls largely to these same members of staff to determine if the older patient is fit to return home from the emergency department. Inaccurate assessment at this stage can result in the older patient returning home with medical and/or functional problems. In turn this can ultimately result in their re-representation at the emergency department.

Transferring older patients to AMUs may help overcome the issue of junior medical staff in emergency departments being expected to rapidly identify and address these complex needs, whilst also trying to manage the unpredictable and fast throughput of acutely ill patients (Hendriksen & Harrison 2001). However it has been argued that AMUs are often inadequately staffed with regard to the provision of specialist geriatric care (Munir 2008).

Situating the Research

a) The Acute Medical Unit (AMU)

The focus of this study is on the experience of older patients and their informal carers (e.g. family, neighbours and friends) in the AMU setting. To date, research conducted on AMUs is still in its infancy. In view of the embryonic development of these units, modest previous research has focused on evidencing the benefits of these units. Studies have been predominately quantitative in nature, with a focus on emergency department waiting times, direct discharge rates, length of stay, mortality levels and re-admission rates (Henley et al 2006, McNeill et al 2011, Moloney et al 2005, Noble et al 2008, Woodard et al 2010). One concerning feature in this body of research is that older patients discharged directly home from AMUs frequently have poor outcomes. That is to say they are either re-admitted or die within the space of a year (Woodard et al 2010). One UK study has found that 55% of older patients discharged within 72 hours from an AMU, subsequently re-

presented within a year. A further 26% had died over the same time period (Woodard et al 2010). In another UK study, 76% of older patients were found to have one or more adverse outcomes such as death, institutionalisation, re-admission, increased dependency or a decline in mental well-being or quality of life in the three months post discharge from an AMU (Edmans et al 2013). It was determined from these studies that poor outcomes are common in older patients discharged home in under 72 hours from AMUs.

Hospital stays however are becoming increasingly shorter with almost 600,000 more patients admitted for one day or less in 2008 to 2009 than five years previously (Arasu 2010). In another UK study, short hospital stays have been raised as a concern for older people (Dobrzanska & Newell 2006). This study found that patients with a hospital stay of under 72 hours were more likely to be re-admitted than patients with a longer length of stay. What is similar in these studies is that older patients were identified as at higher risk of re-attendance if their hospital stay is short (i.e. under 72 hours). Yet the whole purpose of AMUs is to assess and discharge patients in the most expedient time frame possible.

Although patients only stay on the AMU for a short time period, good practice on these units dictates that patient management should involve the care of both a physician and multi-disciplinary health professionals during their stay (Henley et al 2006). The combination of both medical and allied health input should identify both medical and functional concerns, giving a more holistic assessment and subsequently reducing the risk of re-presentation following discharge. The identification of functional concerns is important because research completed in emergency departments has found that as many as 50% of older patients return home unable to complete basic activities of daily living (ADLs), such as climbing in and out of bed, and getting on and off the toilet (Hendriksen & Harrison 2001, Runciman et al 1996). It has been surmised that such functional decline may contribute to older patients re-presenting at the emergency department (Hendriksen & Harrison 2001, Wilber et al 2006). However despite good practice guidelines, a recent survey in the UK revealed that only 56% of AMUs have a dedicated multidisciplinary team for older patients (Percival et al 2010).

b) The geriatrician service

In the absence of multi-disciplinary input on AMUs, an alternative way of pulling together the complex assessment of acutely ill older patients is the Comprehensive Geriatric Assessment (CGA). This has been defined by the British Geriatrics Society as a multidimensional and usually an interdisciplinary diagnostic process (Martin 2010). It has come about in recognition that acute medical illness of older people is often accompanied by co-morbidities, polypharmacy, cognitive decline and functional deterioration. The assessment is usually completed by senior geriatricians and covers medical diagnosis, medication review, mental health assessment, functional ability, and a review of the older patient's social circumstances (Conroy & Cooper 2010). On the basis of the comprehensive assessment the assessor will liaise, as appropriate, with multi-disciplinary health professionals and other specialist services.

There is already a strong body of evidence that CGA delivered in dedicated geriatric units and to frail older patients in the community reduces re-admissions and mortality rates, improves function, and delays nursing home admissions (Baztan et al 2009, Nikolaus et al 1999, Stott et al 2006, Stuck et al 1993). There is less evidence however for the use of CGA with frail older patients being discharged rapidly from hospital, such as in the case of AMUs (Conroy et al 2011). Where CGA is delivered in these circumstances it has been referred to as 'interface geriatrics' (Conroy et al 2011). Here the input is being provided at the acute-community setting interface by a geriatrician who coordinates the patient's on-going care, and refers on to other healthcare professionals as appropriate.

The lack of research into the effectiveness of CGA delivered in acute medical care led to the development of a randomised controlled trial (RCT) in the East Midlands of the UK. This RCT investigated the effectiveness of an interface geriatrician service operating on AMUs across two NHS trusts. These two acute hospital trusts have been identified as having some of the highest re-admission rates in the UK, and thus most at risk of financial penalties, through the government's initiative of non-payment of treatment costs for patients re-admitted within 30 days of discharge (Campbell 2010). At that time the author was employed as a Research Assistant on the above RCT.

The East Midlands RCT intervention incorporated the additional provision of a specialist assessment, provided by a geriatrician, aimed at increasing the length of time that older people remain at home following discharge. This assessment was over and above that provided as standard care. Participants in the intervention group were assessed by the geriatrician before discharge from the AMU and again after discharge with a domiciliary visit. The geriatrician identified and coordinated the patient's care and after care. This care might have included a review of diagnosis, medication review, further diagnostic tests, liaison with informal carers, primary care, intermediate care and other specialist community services. Alternatively it might have included a recommendation to admit the RCT participant rather than to discharge them home (Edmans et al 2013).

A key criterion for participating in the RCT was that participants were identified as at high risk of re-admission. This was achieved by research assistants identifying older patients (aged 70 years and over) being discharged home from the AMUs across the two NHS trusts, who were assessed at risk of re-admission by scoring two or more on the Identification of Seniors at Risk tool (ISAR). This short tool has been validated for use in emergency departments to identify older people at risk of adverse health outcomes (death, institutionalisation, functional decline), and thus at risk of re-admission (McCusker et al 1999). A score of two or higher is associated with high acute care hospital utilisation (McCusker et al 2000).

The success of the geriatrician intervention was measured by the number of days of follow-up that patients spent living in their own homes, compared to a control group who received usual care. Secondary outcomes included death, institutionalisation, dependency in personal activities of daily living, falls, psychological wellbeing and health related quality of life. The findings revealed that there was no difference in the number of days that patients spent at home, or in any of the secondary outcomes between the two groups (Edmans et al 2013). One possible explanation behind the findings is that the patients were assessed just by an isolated geriatrician, and thus the input did not reflect an interdisciplinary diagnostic process, as advocated in comprehensive geriatric assessments (Conroy & Cooper 2010, Martin 2010). Indeed the study authors concluded that a more sophisticated integrated intervention was necessitated to improve the outcomes of these frail older patients (Edmans et al 2013).

c) The doctoral study

As is common for many RCTs, the protocol for the East Midlands RCT included a qualitative component, and it is this qualitative aspect that has provided the opportunity for this doctoral study. The nature of the doctoral study is such that it is appropriate to use the first person hereon. I was appointed as the researcher to design and undertake the qualitative element. The RCT leads were supportive of me shaping the design to meet their objectives, as well as the needs of my doctoral study. The specific requirement of the RCT leads was to incorporate a process evaluation to explore the views of patients and carers who had stayed on an AMU and received the RCT intervention (the interface geriatrician assessment).

A personal exploration of the literature in 2010 revealed that although studies had been completed on the effectiveness of delivering CGA, there was an absence of any literature on the patient perspective of being recipients of this assessment. Thus, there was a clear gap in the literature concerning the patient perspective. Furthermore a broader search of the literature revealed that despite the rapid rise of AMUs across the UK and the concern about the rapid discharge of older patients from acute care settings, no studies were found which focused on the perspective of older patients on UK AMUs. In fact, only one qualitative study was found which focused on the patient experience of AMUs, but this study was conducted in Sweden and may not therefore reflect the UK experience (Sorlie et al 2006). The remaining few AMU studies completed prior to the inception of my study, were quantitative in nature. The review therefore identified a clear gap in the literature, establishing that the patient voice on the AMU experience was largely absent.

Yet the importance of hearing the patient experience as a means of improving healthcare has been emphasised in governmental policy (Bos et al 2013). In the Darzi report (DH 2008a) evaluating patient experience was considered as important as evaluating clinical effectiveness and patient safety (which are considered the central pillars of quality in healthcare). Furthermore research has consistently found that good patient experience is positively associated with better outcomes, when measured through self-assessment of physical and mental health, objective measures of health outcomes, and through patient adherence to treatment and medication (Doyle et al 2013). The importance of evaluating patient

experience has also been recognised in the NHS Mandate (DH 2013a). One of the key objectives in this mandate requires that NHS organisations measure and understand how patients really feel about the care they receive. The 'Friends and Family' test was introduced in April 2013 as part of this mandate to measure patient experience of in-patient services and emergency department care. Hospitals with good scores on this test are financially rewarded, highlighting the value the government subscribes to good patient experience (DH 2013a).

The literature search that I undertook in 2010 also revealed an absence of literature around how an AMU stay impacts on the informal carers of older patients. It is recognised in the literature that older people are returning home from hospital quicker and sicker, and it is the family that provides the first line of defence against problems after hospitalisation (Johnson et al 2001). Research has found that many older people rely extensively on family and friends to help with functional activities following hospital discharge (Arendts et al 2006, McKeown 2007, Mistiaen et al 1997, Popejoy et al 2009). This literature reveals that informal carers provide a lot of the care in the community, and these carers often assume a heavy burden once the patient returns home. Yet often the informal carer is not involved in the discharge preparation, and it is simply assumed by ward staff that they will take on the caregiving role (Johnson et al 2001). Unsurprisingly, if problems arise post discharge, it is often these informal carers who are involved in the decision for the older patient to return to the hospital (Slatyer et al 2013). Informal carers are therefore very influential on re-presentations to the emergency department, and also therefore, to AMUs.

To summarize, at the time of commencing the study in 2010, there was a lack of research on either the patient or informal carer perspective of an AMU stay. Nor was there data on the perspective of patients receiving comprehensive geriatric assessment/intervention. The aim of the study was therefore to capture the patient and informal carer perspective of the entire AMU experience, including their experience of receiving the RCT intervention (the interface geriatrician assessment). The population of interest on which I was to focus, comprised the RCT participants aged 70 years and over with an ISAR score of two or more.

At a later stage, in 2013, a second literature review was completed to identify any research that might have been conducted on AMUs since the initial literature search was completed. This search revealed new studies in the form of two qualitative studies (Ferguson et al 2013, Slatyer et al 2013) and two quantitative surveys (Lees & Chadha 2011, Sullivan et al 2013). Only one of these studies (Slatyer et al 2013) was focused on older people. The emphasis of that study was on re-presentation to the unit rather than the actual AMU stay. Thus these four studies only provide limited insight into the experience of older people and their informal carers regarding an AMU stay. Therefore at the time of writing up the thesis, knowledge on how older people and their informal carers perceived the experience of a short stay on an AMU remained limited.

Reflexivity

a) Situating self in the research: Personal interest

The study was influenced by both the need of the RCT to have a process evaluation but also by personal and professional interests. To understand how the study was situated it is helpful to provide some background information, alongside why the study was considered important. Reflexivity has been defined by Underwood et al (2010) as the acknowledgement and identification of the researcher's place and presence in the setting, context and social phenomenon that they seek to understand. More significantly it includes the use of these insights to critically examine the entire research process. In this way it is important that the reader is able to understand from the outset the location of myself in this study. Attempts have been made to be open and transparent about personal positions and interests, and how each of these may have shaped the research. Ultimately it is important to recognise that the study was heavily influenced by personal interests and concerns.

At the time of commencing the study I was employed as a research assistant on the RCT. This necessitated spending time on the AMU recruiting participants onto the trial. Working on this Unit raised some personal concerns about the position of the older patients on the AMU who were observed to be in an environment that was busy and chaotic. Patients of all ages were constantly being admitted and discharged from the AMU, and the Unit was in a constant state of flux. Patients

were observed to be confused and sometimes very agitated, and staff were persistently busy and under constant pressure from the emergency department to free up beds. The AMU staff were therefore pressured to discharge patients quickly, either back to the community or transfer them onto a medical ward. However bed shortages elsewhere meant that the latter was frequently problematic, and patients were often discharged home instead. Whilst on the AMU patients had to fit into an unfamiliar and alien environment at a time when they were particularly vulnerable. The systematic review of qualitative literature by Gordon et al (2010) similarly revealed that patients feel vulnerable, anxious and insecure in the emergency department. It follows that this vulnerability extends to the AMU, where assessments and diagnostic tests are on-going, and patients are fearful of the seriousness of their condition. Their lives are effectively in the hands of the medical professionals who have the necessary knowledge and skills to help them.

This brought a critical perspective to the study, borne from an unease that the voice of older patients, those on the receiving end of acute medical care, were not well heard. This unease was reinforced by past experience of working in a department dominated by quantitative and positivist researchers. The research trials completed by this faculty were focused on evaluating complex interventions to improve health, and were predominately Phase ii (feasibility) and Phase iii (definitive randomised controlled) trials (Campbell et al 2009). In these medical trials there was a lack of exploration into the meaning of the interventions for the participants, and this appeared to be a shortfall in need of addressing, along with exploration of how participants perceived and interpreted their overall acute medical care experience.

My perception at the inception stage of the present study was that older patients' perspectives were undervalued compared with those of healthcare professionals. However it was recognised that this view may not match that of the patients. I wondered how older patients, who are acutely unwell, perceived the clinical and medical environment of the AMU. The question raised was how older patients, and indeed their informal carers, perceived the whole journey from admission through to discharge.

b) Situating self in the research: Professional interest

One of the major concerns posed for me by the RCT was the lack of an immediate multi-disciplinary team working alongside the geriatricians. My background as an occupational therapist gave rise to concerns that the functional needs of patients might be overlooked by the geriatrician emphasis in the RCT intervention. These functional needs are commonly referred to as the patient's Activities of Daily Living (ADLs). In the acute environment the role of the occupational therapist is to focus on assessing the patient's ability to complete their ADLs, and this includes everyday activities such as getting on and off the bed or toilet, washing and dressing, and preparing drinks and meals. The occupational therapist assesses whether additional support or equipment is required to enable patients to safely return home and assesses the wider picture of the patient's care, with the aim of reducing the risk of the patient returning to hospital (Blaga & Robertson 2008). It has been recognised in the literature that therapists play a vital role on AMUs in facilitating safe and timely discharges, or in intervening to recommend admission to a ward in preference to discharge (Robinson et al 2014). Indeed previous trials which have investigated the effectiveness of comprehensive geriatric assessment (CGA) have included a multi-disciplinary team as part of the intervention. The outcomes of these studies have been positive, including reduced re-admission rates and improved functional status (Caplan et al 2004, Nickolaus et al 1999, Stott et al 2006).

Research has found that one of the most common anxieties of patients in emergency departments is being unable to complete their ADLs on returning home (Byrne & Heyman 1997). These anxieties appear well founded as other research completed in both emergency departments and acute hospitals has found that older people do return home with functional limitations (Henriksen & Harrison 2001, Jones et al 1997, LeClerc et al 2002, McKeown 2007, Mistiaen et al 1997, Runciman et al 1996). At the planning stage of the study I was acutely aware that occupational therapists were not employed on the AMUs across the two hospital trusts in which the RCT was being completed. That is despite recommendations that AMUs should have dedicated allied health staff, which includes occupational therapists, working on such units (Henley et al 2006). Furthermore the RCT intervention also lacked an immediate occupational therapist working alongside the

geriatrician. I pondered whether geriatricians working alone on the RCT would focus disproportionately on the patient's medical and cognitive needs. Important as those are, such focus could be to the detriment of their functional needs. This could create the risk of patients returning home with functional difficulties and these patients would thus be at higher risk of re-presentation at the emergency department (Wilber et al 2006).

To summarize, I realised that the study was heavily influenced by my day to day observations of the AMU and by my own professional background as an occupational therapist. I was determined that the study would have a holistic approach and evaluate the entire AMU experience, incorporating both the RCT intervention, and the participant experience in relation to their ADLs once back home.

Study Aim and Objectives

The aim of the study was to gain an in-depth understanding of the older patient and informal carer experience of an AMU stay. All the factors outlined above ultimately influenced the objectives of the study. Some were determined by the needs of the East Midlands RCT process evaluation for which I was employed, and some by personal and professional curiosity.

The four objectives of the study were:

- To explore older patient and informal carer perspectives of the care and treatment received whilst on the AMU.
- To explore older patient and informal carer perspectives of the care and treatment received relating to discharge from the AMU.
- To explore older patient and informal carer perspectives of the interface geriatrician service.
- To explore how a short stay on an AMU impacts on older patient and informal carer perceptions of their ADLs once back home.

Study Design

A constructivist philosophy underpinned the study, focused on ascertaining how older patients, and their informal carers, perceived and construed the AMU

experience. A study design was developed that would best meet the above objectives. A search of the relevant literature revealed two popular methods for eliciting patient and carer perspectives; patient satisfaction surveys and in-depth interviews. As the RCT protocol stipulated a qualitative study, the latter method was adopted. Furthermore it was recognised that this method would provide a greater depth of insight than a survey. Face to face interviews were undertaken with individual patients, or in pairs with their informal carers, to achieve a sample of 18 patients and six informal carers. Data went on to be substantively analysed through the processes of both thematic and narrative analysis, complemented by data display development, as an aid to qualitative analysis.

Organisation of the Thesis

The thesis includes chapters on the following:

- A literature review (completed prior to commencement of the study, and refreshed following data collection to take into account up-dated knowledge in the field).
- A methodology chapter. This includes the methodology informing the study, the methods employed, and details on the data collection and data analysis stages of the study.
- A findings chapter, which details the themes constructed from the analysis stages of the study.
- A reflexivity chapter which considers my presence in the research process.
- A discussion chapter which appraises the underlying methodology and methods used, and synthesises the study findings with other related research relevant to the field of inquiry.
- A conclusion chapter, outlining the study recommendations at the level of policy, management and the individual healthcare practitioner, before summarising and drawing the study to a close.

Chapter Summary

This chapter has provided the background behind the identified focus of the study. It has outlined how the study was positioned in relation to a larger RCT. The limited research completed in the field has been highlighted and the gaps in what is known

about patient and carer perspectives of AMU stays, geriatrician intervention at the acute-community interface, and resettlement home post discharge have been acknowledged. Finally, the influence of my own position and interests in the study were acknowledged through reflexivity.

The next chapter is focused on the literature review, used to develop and refine the above four study objectives.

Chapter Two

Literature Review

Introduction

This chapter presents a systematic examination of the literature in the field of acute medical care in relation to the four objectives of the study. The aim of the literature review was to critically examine the content of the individual studies and establish the overall comprehensiveness of the research conducted in the field. The literature review was completed in two stages: firstly in advance of designing the study, and secondly after data collection was completed. The primary literature review placed the study in the context of existing research in the field, and provided justification for the study. The second stage of the literature review identified new knowledge that had emerged in this field during the course of the study and informed my interpretation and discussion of the study findings. Although two specific periods of time were allocated to the literature review, constant attention was paid to any appropriate literature coming to light during the intervening period.

Search Strategy

The primary literature search was completed from September 2010 to January 2011. Electronic databases used were: Cumulative Index to Nursing and Allied Health Literature (Cinahl), Medical Literature On-Line (Medline), Applied Social Sciences Index and Abstracts (ASSIA), and Allied and Complementary Medicine (AMED). Systematic reviews of qualitative literature were also referred too, such as that by Gordon et al (2010), as an aid to designing the search protocol. The term 'patient experience' has been found to prove problematic in previous searches (Doyle et al 2013) and so broad search terms were used. Key words in the searches related to the study objectives. The details of this protocol and rationale behind decisions made is provided in Appendix 1a.

A total of 52 papers met the inclusion criteria of the primary literature search protocol. Each of these papers was critiqued using the Health Care Practice Research and Development Unit tool for guidance (Long et al 2002). This tool has

three versions, each capturing the unique paradigms of qualitative, quantitative, or mixed method research. This tool was adapted to ensure the focus of the critique was upon the methodology of the study, rather than upon clinical or practice implications (see Appendix 1b). The critique of each study resulted in a judgement being made on whether the study was deemed methodologically poor or robust. Ballinger (2004) has highlighted the importance of evaluating studies according to the ontological position assumed. The degree to which studies were judged to be rigorous was thus determined by both the ontological position and design of the study.

The second literature search was completed from June 2013 to January 2014. Expert support was elicited to limit the likelihood of any key literature being missed. This could have been overlooked in the primary search, due to the variety of names associated with AMUs, and the recognised limitations of the search facilities on these databases. The literature search protocol was subsequently modified to include an expansion of the AMU search terms, and range of databases (see Appendix 1a). The secondary literature search revealed a total of 25 papers.

The 77 papers identified through the combined literature searches were within the fields of the emergency department experience, the acute hospital experience, perception of geriatrician care, the hospital discharge experience and perception of functional abilities. There was invariably some overlap, with some papers reporting on experiences across more than one field. For ease of reading, the literature below has been divided into each of these domains.

The Emergency Department Experience

The AMU forms part of the emergency care pathway (Lees & Chadha 2011) and consequently the literature review commenced with a search of emergency department papers. Twenty three papers were found on the emergency department experience meeting the criteria of the protocol. See complete list in Appendix 1c, Table 1.

The 23 papers were searched for recurring themes and this revealed that research has predominantly focused on patients experiencing non-life threatening illnesses.

Despite this, the patients in these studies visited the emergency department because they believed their condition was serious, and feelings of security were gained once they were in the care of staff in the emergency department (Baraff et al 1992, Nyden et al 2003). The physical environment was often described as poor with comments made about over-crowding, noise, limited space, lack of privacy and insufficient warmth (Coughlan & Corry 2007, Kelley et al 2011). Patients frequently spoke about being nursed on uncomfortable and hard trolleys (Baraff et al 1992, Britten & Shaw 1994, Nyden et al 2003, Watson et al 1999). Basic needs such as the need for food, drinks, pain relief, privacy, comfortable beds and warmth were identified as important (Britten & Shaw 1994, Frank et al 2011, Kelley et al 2011, Nyden et al 2003). Higher level needs, such as being involved in treatment choices were relinquished to the staff, and patients reportedly adopted a passive role in their care (Britten & Shaw 1994, Elmqvist et al 2011, Nyden et al 2003, Nystrom et al 2003a, Nystrom et al 2003b).

The studies also revealed that the emergency department stay was characterised by long periods of waiting, with patients frequently left alone for hours, feeling abandoned (Baraff et al 1992, Britten & Shaw 1994, Elmqvist et al 2011, Kihlgren et al 2004, Nystrom et al 2003a, Nystrom et al 2003b, Olofsson et al 2012). The patients accepted however that the most critically ill were treated first, and thus patients were not seen in order of arrival (Baraff et al 1992, Britten & Shaw 1994). There was a general perception amongst patients that the staff in the emergency department were busy, often dealing with others in more need of care than themselves (Coughlan & Corry 2007, Kelley et al 2011, Nyden et al 2003, Nystrom et al 2003a, Nystrom et al 2003b). The perception of the quality of nursing care was dependent upon individual staff rather than upon the presence of a collective caring culture (Nystrom et al 2003a, Nystrom et al 2003b). Despite raising issues around their care, patients were reluctant to criticise staff and proportioned blame externally, towards managers, politicians and 'the system' (Kihlgren et al 2004, Nyden et al 2003, Nystrom et al 2003a, Nystrom et al 2003b).

Only four of the emergency department studies were completed in the UK, and many of the cited studies were judged to be methodologically weak using the Health Care Practice Research and Development tool (see Appendix 1c, Table 1).

Furthermore only nine of the emergency department studies focused on just older people, the population of interest. The perceptions of older people may differ from those of the younger population, and the emergency department literature suggests that older people are more satisfied with their care and treatment than younger patients (Frank et al 2011, Sun et al 2000).

To summarize, the focus of these studies was on the emergency department stay, and not on the patient journey further upstream. Indeed as these studies focused on non-urgent patients, it is likely that many returned directly home. Yet patients nursed on AMUs can spend up to 72 hours on the Unit before returning home. It followed therefore that the literature review needed to incorporate more than just the emergency department, and the review was therefore expanded to incorporate the experience of acute inpatient medical care.

The Acute Hospital Experience

A total of 26 papers fitted the search criteria for the acute medical care papers. See complete list in Appendix 1c, Table 2.

Satisfaction surveys are the most popular approach for measuring patient experience (Lees & Chadha 2011), and are increasingly being employed in the NHS. It is not surprising therefore that the literature in the field of acute medical care included ten satisfaction surveys. These surveys were completed not only in the UK but also internationally (Bruster et al 1994, Charles et al 1994, Danielsen et al 2007, Elliott et al 2009, Hancock et al 2003, Hordacre et al 2005, Jenkinson et al 2002, Jones & Lester 1994, Lees & Chadha 2011, Thi et al 2002). These satisfaction surveys reveal high levels of patient satisfaction with acute medical care. However one major criticism of satisfaction surveys is that they have a tendency to inflate levels of satisfaction, and fail to elicit more critical responses from the patient's point of view (Calnan et al 2003, Fielden et al 2003).

Concerns about the reliability of satisfaction measures have led researchers to move away from satisfaction surveys to examining patient complaints. Three such studies were found amongst the acute care papers. The first two studies examined complaints received from the Patients Advisory Committee in Sweden. These two

studies revealed that a significant reason behind complaints was attributed to patients and/or informal carers experiencing negative encounters with the healthcare staff. In the first study by Jangland et al (2009) it was revealed that insufficient respect and insufficient empathy were the most common reasons behind complaints received. In the second study by Eriksson and Svedlund (2007) narrative interviews were completed with complainants. The findings revealed that the patients felt powerless and small, and spoke of a need to fight not only their disease but also the staff providing their care. The third study examined complaints received across two emergency departments in Scotland (Bongale & Young 2013). The findings revealed that the number of complaints received was low at only 0.40% per 1,000 patient visits. However of those complaints received, 63% were non-clinical, with half of these complaints relating to poor communication, attitude and behaviour of staff. These three complaint studies are similar in so far as complaints predominately revolved around negative professional encounters. However a limitation behind using complaints, as was done by these studies, is that patients may be reluctant to go through the complaint procedures. Hence this method fails to capture feedback on care and treatment received by the majority of patients.

Other studies completed on the experience of acute medical care have adopted a qualitative approach. Patients in these studies, like those in the above satisfaction surveys, made positive comments about the staff, describing them as caring, friendly, helpful, attentive and compassionate (Ferguson et al 2013, Nakano et al 2008, Shattell et al 2005, Vydelingum 2000). Furthermore staff working in the acute medical environment were perceived as both efficient and technically competent, resulting in patients feeling safe and secure in this setting (Nakano et al 2008). Although positive comments were made about the acute medical staff, it was recognised that individual staff could either enhance or damage the experience (Shattell et al 2005, Webb 2007). Similar to the emergency department studies, the staff in the acute medical environment were perceived as busy (Vydelingum 2000) and patients had a tendency to minimise their negative experiences, often making excuses for staff (Shatell et al 2005, Webb 2007).

Seven papers were located amongst the acute care papers which were considered as something akin to an AMU experience. Some of these papers were explicitly labelled as an AMU study (Ferguson et al 2013, Lees & Chadha 2011, Slatyer et al 2013, Sullivan et al 2013), and some were identified as such from reading through the description of the service being evaluated (Arendts et al 2006, Mace 1998, Sorlie et al 2006). This highlights the difficulty of identifying studies which have been conducted with patients experiencing an AMU stay.

The first study by Arendts et al (2006) was a quantitative study conducted on an emergency short stay unit in Australia. The study incorporated both a satisfaction survey and examination of patient demographic and clinical data. The patients in the study were surveyed six to eight weeks following discharge. As with the earlier reported satisfaction surveys, these patients reported high levels of satisfaction with all aspects of their care. However the computerized data revealed that a large number of the patients made unscheduled visits to their medical practitioner post discharge for the same problem for which they had been admitted to the Unit. Furthermore, 9% of the patients were actually re-admitted for the same problem.

The second study by Mace (1998) examined complaints received on an Observation Unit in Ohio. A total of 11,042 patients were admitted to this Unit over a 26 month period, and only 28 patient complaints were received during this time period. The largest number of complaints, in keeping with the earlier reported complaint studies, related to staff attitude and behaviour. These complaints included a perception that the staff were 'abrupt', 'rude', 'uncaring', 'unprofessional', and 'inattentive'

The third study by Sorlie et al (2006) was conducted on an Acute Care Ward in Sweden, where patients were admitted for observation for up to three days before either being admitted to another ward, or discharged back home. This was a qualitative study, which like the earlier qualitative studies, found that patients perceived that the staff working on the Ward were both friendly and helpful. However the findings revealed that these patients were anxious about their diagnosis and felt in a vulnerable position. They consequently felt afraid to be perceived as a nuisance by the busy staff.

The fourth and fifth studies were also qualitative in nature. These two studies, like all of the above studies, were completed outside of the UK, and may not therefore reflect the UK experience. The fourth study was conducted with patients across a range of ages, and thus included the perception of both younger and older patients (Ferguson et al 2013). The findings of this study revealed that less than half of the patients were satisfied with their care delivery. The patients spoke about the Unit being busy and identified ineffective communication as an issue. The fifth study was conducted with older patients, and thus differed from all of the above AMU studies (Slatyer et al 2013). The focus of this study was on patients who had re-presented to the hospital within 28 days of discharge from an AMU. The findings were primarily concerned with the discharge process rather than the overall experience of the stay on the AMU. However, as in the above study, the patients spoke about the AMU being busy, and the consequent constrained staff communication.

The sixth and seventh studies were both quantitative in nature, but unlike all of the above studies explored the AMU experience from a UK perspective. However neither of these studies were conducted with just an older population. The sixth study by Lees and Chadha (2011) was essentially a descriptive account of the development of a satisfaction survey in which, as part of this development utilised two patient diaries to record the patient's journey. These diaries only provided superficial evidence of the patient experience, but once again suggested that the AMU was busy and that waiting was an issue. The last paper by Sullivan et al (2013) evaluated the findings of the 2010 Adult Inpatient Survey. The authors used the data from this survey to compare what they suspected were AMU admissions (group A) against the experience of other short stay unscheduled admissions, to specialities other than medicine (group B), and short stay scheduled admissions (group C). The AMU stay scored less well on many of the survey items compared to the other two services, and specifically scored less well on privacy, involvement in decisions, and staff communication. One weakness of this study is that the authors were using secondary data and could not therefore be certain that the all the patients in group A were cared for on AMUs.

To summarize, the acute hospital care papers reveal high levels of satisfaction with care, but at the same time identified negative issues around this care, relating to staff attitudes, behaviour and communication. Only four of the acute care papers were focused on older patients (Hancock et al 2003, Jones & Lester 1994, Parke & Chappell 2010, Slatyer et al 2013), and only seven papers explored the patient/informal carer experience of an AMU stay (Arendts et al 2006, Ferguson et al 2013, Lees & Chadha 2011, Mace 1998, Slatyer et al 2013, Sorlie et al 2006, Sullivan et al 2013). These few studies suggest that AMUs are perceived by patients as excessively busy and that there are issues around staff communication. Only one of the AMU studies explored the perspective of an older population, and this study was focused on just those patients re-presenting to the hospital following discharge. Research remains limited therefore on the perspectives of older patients (and their informal carers) on the UK AMU experience.

Perception of Geriatrician Care

As the objectives of the study incorporate both the experience of an AMU stay and the experience of receiving the RCT intervention (the interface geriatrician assessment) the literature search was expanded to include patient and informal carer perspectives of geriatrician care and treatment. Three papers met the criteria of the literature search protocol and are discussed below.

The first study by Arbaje et al (2010) evaluated a floating geriatric interdisciplinary team providing input across general medical wards of a large American university teaching hospital. The team was led by a geriatrician or a geriatric nurse practitioner who co-managed geriatric syndromes with inpatient physicians and nursing staff, whilst also providing staff education on geriatric care. Specialist geriatric advice and support was also offered post discharge to primary care providers, along with telephone follow-up with the patients. The aims of the study were two-fold; firstly to assess the effect of the quality of transitional care (from the hospital to the community), and secondly to assess patient satisfaction with that care. To assess the effectiveness of the service the model was operationalised to older patients on two medical wards, whilst patients on two other medical wards received usual care, and served as the control group. The findings indicated that the intervention slightly improved the transition of care, and that satisfaction was

higher amongst the intervention than the control group. However both of these findings were not statistically significant. Furthermore the outcome measurements did not measure either functional status or re-admissions, despite the authors stating that good transitional care reduces re-admissions.

The second study by Eijken et al (2008) evaluated the feasibility of implementing a Dutch geriatric intervention programme. This programme differed from the above, in so far as, it was entirely nurse led (supported by two geriatricians), and delivered in the community. The perspectives of general practitioners, staff delivering the programme, informal carers and patients were sought. However, only 11 of the 57 patients receiving the programme could be interviewed due to cognitive concerns and re-admissions. Overall the intervention was perceived to cater well for general practitioners as it provided a thorough analysis of patients' cognition, mood and mobility problems, all areas identified as problematic by the general practitioners. The recipients of the intervention (general practitioners, informal carers and patients) appreciated the support offered by the intervention, although the health outcomes were less reported. Ultimately, the programme was assessed to be feasible to implement into daily practice.

It is important to note that due to the design limitations of the above two studies, it is not possible to isolate the geriatrician aspect of the intervention from the overall interdisciplinary service provided by both the inpatient and community teams. However the third study by Limbourn and Celenza (2011), conducted in Australia, differs from the above two studies, in so far as it focuses specifically on the patient perception of doctors. This paper reported on the design and implementation of a satisfaction survey focused on the caring component of emergency department doctors. The survey was completed with 467 patients. As is common in satisfaction surveys, high levels of satisfaction were recorded with 93.3% of patients rating their care in the emergency department by the doctors as good to excellent. The patients free text responses revealed the attributes most liked and disliked in respect of emergency doctors. Unsurprisingly, patients appreciated friendly, polite, attentive, caring, concerned, efficient, competent and thorough doctors. They also appreciated doctors who demonstrated good listening skills, provided explanation and advice, and provided the opportunity for patients to ask questions. Conversely

patients disliked hurried and distracted doctors, and those possessing poor communication skills. Most of the negative attributes were system related rather than attributed to the doctor.

To summarise, only one paper was found which focused on the patient perspective of care provided by doctors, and this was limited to the emergency department. It included patients of all ages, and therefore was not confined to the perspective of older patients. No papers were found which focused solely on the patient perspective of geriatrician care and treatment. Furthermore, none of these studies were completed in the UK, and all were judged to have methodological weaknesses using the Health Care Practice Research and Development tool (see Appendix 1c, Table 3). There is an absence of research therefore on the patient perspective of geriatrician care and treatment in the UK.

The Hospital Discharge Experience

In line with the study objectives, the literature review incorporated a search of papers in relation to the discharge experience, and 17 papers were identified. See complete list in Appendix 1c, Table 4.

These studies explored the acute hospital discharge process from the patient, informal carer and healthcare professional perspective. The studies have highlighted how patients often felt excluded from decisions regarding their discharge, and reported a tendency to adopt a passive role in the discharge process (Huby et al 2007, Jewell 1993, Richardson et al 2007). Even if patients had concerns regarding their discharge they were reluctant to negotiate the length of their stay, perceiving that staff 'knew best' and were the 'experts' (Clarke et al 2010, Roberts 2002). In keeping with the positive skew of satisfaction surveys (Jenkinson et al 2002) many of the studies revealed high patient satisfaction with discharge (Bruster et al 1994, Bull et al 2000, Jones & Lester 1994). On the other hand, informal carers were more likely than patients to be dissatisfied with discharge arrangements, including length of notice, and were more likely to think that patients had been discharged prematurely (Grimmer et al 2000, Jones & Lester 1994). The informal carers in these studies felt they occupied a peripheral position when it came to discharge decisions (Foust et al 2012, Jones & Lester 1994). These carers reported that they were not involved in the decision process

and were frequently left with feelings that they were taken for granted (Pearson et al 2004). Informal carers reported their own needs were not recognised and they were left juggling their needs, their family needs and those of the patient (Pearson et al 2004, Procter et al 2001).

Only one study was located which was focused on patients discharged from an AMU (Slatyer et al 2013). This is the study outlined above in the acute care papers, and it explored the perceptions of older patients who re-presented at the hospital following discharge from an AMU. Twelve older patients, 15 informal carers, and 35 hospital and community healthcare professionals were interviewed in this study. The findings revealed that patients often re-presented at the hospital following their discharge from the AMU due to recurrence of symptoms, functional decline, or due to the substantial level of input required from their informal carers. It was reported by the healthcare professionals that these patients were often classed as 'borderline' at the time of discharge, but were discharged because of the high demand on AMU beds. Shortage of AMU beds may have thus resulted in premature discharge, and subsequently these patients re-presented at the hospital.

Another study by Hesselink et al (2012) similarly found that healthcare professionals feel under pressure to empty acute hospital beds. This large study involved interviewing 53 patients and/or informal carers and 139 healthcare professionals (physicians and nurses) across five European countries. The healthcare professionals reported that bed shortages frequently resulted in premature discharges, and the patients spoke of sudden and abrupt discharges that left them feeling overwhelmed. The staff recognised that a lack of time was a cause of less than optimal discharge consultations with patients and informal carers, whilst the patients and informal carers spoke of insufficient emotional support provided at discharge. This included staff not spending enough time listening to the patient and informal carer concerns. These findings have been reflected in a UK study of older patients and informal carers (Knight et al 2011). The findings of this study revealed a perception that too little or no information was provided on discharge and, once again, this was attributed to staff being busy and having insufficient time to provide information.

To summarise, only one study was located which focused on the discharge of older patients from an AMU setting (Slatyer et al 2013). The remaining studies were conducted in the acute medical setting, and most of these studies were judged to have methodological weaknesses using the Health Care Practice Research and Development tool (see Appendix 1c, Table 4). Furthermore, several of these studies were completed with an adult as opposed to an older population. Further research is needed on the discharge process, and how this impacts on older patients and their informal carers. This is an important area to study as it is recognised that patients are being discharged home from the acute medical setting 'quicker and sicker', resulting in increased dependence, and necessitating assistance from informal carers (Grimmer et al 2000, Johnson et al 2001). The resumption of ADLs post discharge is explored further in the literature below.

Perception of Functional Abilities

Thirteen papers were found focusing on patient perspectives of their ability to complete their activities of daily living (ADLs) post discharge, meeting the criteria of the literature search protocol. See complete list in Appendix 1c, Table 5.

The studies revealed that many patients were discharged home from acute hospitals with problems managing their ADLs, and were often reliant upon their informal carers. These studies revealed that older patients experienced problems across the full spectrum of ADLs following an acute medical admission. Mistiaen et al (1997) surveyed 145 older patients being discharged from an acute care setting in Amsterdam. This survey revealed that additional help with ADLs was required post discharge. Housekeeping was the area of greatest difficulty with 77% (n=112) reporting problems, but a further 53% (n=77) of patients had difficulty completing personal care tasks. Another study by Clark et al (1997) of 76 older patients discharged from medical wards in Australia found that carers (n=52) reported high levels of patient dependency with domestic ADLs. 60% of patients required assistance with shopping, 55% with meal preparation, and 68% with housework.

Difficulties completing ADLs post discharge have also been reported in studies completed in the UK. A study by Coffey and McCarthy (2013) of 335 older patients discharged from medical wards found that 63 needed support with their personal

ADLs, whilst 69.2% required support with domestic ADLs. At six weeks post discharge, nearly one-quarter of patients had been re-admitted. Of those patients still at home the need for the proportion requiring support rose by 9% for personal ADLs, and by 10% for domestic ADLs. Yet the amount of formal support from services was only minimally increased. Another UK study by Farnsworth et al (1995) of 23 older emergency department patients revealed that the problem of resuming ADLs is not only limited to patients admitted to acute medical wards. This study revealed that 26% (n=6) of older patients attending the emergency department similarly had anxieties about completing their ADLs on discharge, anticipating that they would need support with these activities.

The findings from the acute medical literature suggest that older patients have difficulty completing their ADLs upon their return home, and that their informal carers are often the main providers of support. Family, friends and neighbours have been identified in several studies as the main providers of help and in many cases have been the only reason that patients can remain at home (Farnsworth et al 1995, Fitzgerald Miller et al 2008, Gage et al 1997, McKeown 2007, Mistiaen et al 1997).

A further study was located that explored the recovery process of 20 older patients discharged home in the UK following an acute hospital stay. At six weeks post discharge, many of these patients (n=9) reported a desire to get back to normal. However the patients reported experiencing mobility restrictions (n= 14) and problems mobilising outside of the home (n=9). They also reported psychological issues, such as loss of confidence (n=6) and fear (n=4). These mobility and psychological issues affected the ability of the patients to return to a 'normal' level of functioning (Dyas & Thom 2002). There were however some methodological weaknesses in the design of this study, including an unclear sampling framework which lacked any details on the characteristics of those interviewed. The authors concluded that the study findings highlighted a need for reassurance and confidence building as part of the services that should be provided post discharge. Indeed it has been recognised by the Audit Commission (2000) that patients who have returned home from acute hospital wards may need access to rehabilitation

from multidisciplinary teams operating in the community, as a means of rebuilding their confidence to cope with their ADLs.

One of the weaknesses highlighted by the literature review was that only four of the above studies were completed in the UK, and all of these studies were judged to be methodologically weak using the Health Care Practice Research and Development tool (see Appendix 1c, Table 5). Furthermore, none of the studies, with the exception of the emergency department study (Farnsworth et al 1995), were focused on older patients with a stay of under 72 hours, as should be the case in those patients experiencing an AMU stay. Indeed the authors of several of the studies noted that their sample was composed of patients with an average length of stay exceeding three days (Coffey & McCarthy 2013, Fitzgerald Miller et al 2008, LeClerc et al 2002), and some of the studies specifically excluded patients with a hospital stay of under two days (Mamon et al 1992, McKeown 2007, Mistiaen 1997, Small & Graydon 1993). The assumption seems to have been that a short length of stay has less impact on ADLs post discharge. However this assumption can be challenged by studies completed with patients discharged from the emergency department, which have revealed high rates of dependency in ADLs (Hendriksen & Harrison 2001, Runciman et al 1996). More specifically the study by Farnsworth et al (1995) suggests that even older patients independent with their ADLs prior to an emergency department visit may need assistance with these same activities on returning home.

To summarise, these ADL studies reveal that older patients return home from the acute medical setting with functional difficulties. These difficulties impact on informal carers, who provide the majority of support. However there is an absence of research on the older patient's perspective of their functional ability following a short hospital stay, such as that experienced following an AMU admission. This gap in the knowledge needs addressing as ADL difficulties can ultimately contribute to an older person returning to the acute hospital to seek assistance. This conclusion has been supported by several studies (Carlson et al 1998, Slatyer et al 2013, Wilber et al 2006).

Outcome of Literature Review

The literature review revealed that there have been few studies conducted in the acute medical setting concentrating on older patient and informal carer perspectives. More specifically, there has been a lack of research into the perspective of older patients and informal carers experiencing an AMU stay. The literature review was evaluated in respect of the four objectives of the study.

Objective one: *'The perspective of the older patient and their informal carer of the care and treatment received whilst on an AMU'*. The literature review revealed a mix of qualitative studies and satisfaction surveys completed in the acute medical setting, both in emergency departments and on acute medical wards. These studies revealed patient perspectives of care and treatment in the acute medical environment. However only seven of these studies were completed with patients experiencing an AMU stay and only one of these studies was confined to just an older population. The review revealed that there is an absence of knowledge on how older patients and informal carers perceive the AMU experience.

Objective two: *'The perspective of the older patient and their informal carer of the care and treatment received relating to discharge from the AMU'*. Once again the literature review revealed a mix of qualitative studies and satisfaction surveys, completed in the acute medical environment. Overall, the reports of these studies were evaluated to be methodologically weak. Only one study focused on the experience of discharge from an AMU and that study was completed in Australia. Unfortunately the focus of the study was more upon ascertaining the reasons for re-presentation to the emergency department, rather than on an exploration of the actual discharge process. The review revealed an absence of knowledge on how older patients and their informal carers perceive the discharge experience from AMUs.

Objective three: *'The perspective of the older patient and their informal carer of the interface geriatrician service'*. Only two studies were found which explored the perspective of patients and their carers of geriatrician care, but unfortunately neither of these studies isolated the geriatrician aspect of the care from other members of the multidisciplinary team. A single study was found which focused

just on the perspective of care provided by emergency doctors. However, as with the other two studies, this study was completed outside of the UK and, in contrast to the geriatrician studies, was not just confined to the perspectives of older patients. The review revealed an absence of knowledge on the older patient and informal carer perspective of geriatrician care and treatment.

Objective four: *'The perspective of the older patient and their informal carer on how a short stay on an AMU impacts on ADLs once back home'*. The literature review revealed several studies conducted with patients following an acute hospital stay, however most of the patients in these studies had a length of stay of over three days, and none were completed with patients who had experienced an AMU stay. The review revealed an absence of knowledge on the functional abilities of older patients (and any possible impact on their informal carers) following an AMU stay.

Chapter Summary

The literature review confirmed a suspected absence of knowledge around the four objectives of the study, justifying a need for the research. The review revealed substantial gaps in the existing knowledge on the perspectives of older patients and their informal carers on the AMU experience. This incorporates the patient journey from admission, to discharge, to the assessment and intervention of a geriatrician, and to their resettlement back home. An AMU stay provides a unique patient experience, in so far as patients admitted onto these units present as emergencies, and remain on the AMU for under 72 hours. Many of these patients are then discharged directly home. There has been limited research on how older people and their informal carers, perceive such a short length of stay when admitted through this emergency route. Their perspective is important because if their needs and expectations are not met, and if problems are perceived to continue post discharge, then this can precipitate their return to the emergency department. The NHS is under increasing strain and resources are not infinite. There is a need therefore for further study focused on older patient's experiencing a short length of stay on AMUs, who are recognised at high risk of re-attendance.

In the next chapter I will discuss the underpinning design of the study and the methodology used to meet the above four objectives of the study.

Chapter Three

Methodology

This chapter is divided into three parts, the first part outlines the underpinning ontology, epistemology and methodology of the study, the second part details the method of data collection, and the final part outlines how these data were analysed and interpreted.

Part One: Theoretical Underpinning

This section of the chapter focuses on the theoretical underpinning of the study, including the ontology, epistemology, and methodology which informed the gathering, analysis and interpretation of data.

Theoretical Framework

The underlying methodology was influenced by both the aim and objectives of the study. This required an exploration of the experience of older patients and their informal carers of an AMU stay. To determine that experience, either a quantitative or qualitative approach could be employed. The former enables the researcher to accumulate data from large numbers of patients, whilst the latter is focused on smaller but more in-depth samples. As outlined in the previous chapter, quantitative methods, such as satisfaction surveys, often result in overly positive findings, and have been criticised for failing to discriminate effectively between good and bad practice (Jenkinson et al 2002). As a consequence of this recognised weakness, it has been recommended in the literature that more detailed questions are required about the hospital stay, than can be achieved by quantitative surveys (Bruster et al 1994, Calnan et al 2003, Fielden et al 2003, Jenkinson et al 2002). It has been argued by these authors that qualitative methods enable the identification of both strengths and shortfalls in the patient's care delivery. It was determined therefore, that a qualitative approach would most appropriately meet the aim and objectives of the study, whilst also fitting with the requirements of the RCT process evaluation.

The aim and objectives of the study similarly determined the way of thinking about the social reality being studied (Punch 2006). The study was guided by a

constructivist interpretivist paradigm; the belief that thought is at the very heart of what is to be human. This belief rests on the assumption that humans are intelligent beings, who filter information through the mind and construct reality. Constructivism rests on the belief that the world is socially constructed and as such there are multiple interpretations and descriptions for each and every event or experience. Constructivism is about establishing what these events mean to individuals, and how they understand and create meaning around a given phenomenon (Creswell & Plano Clark 2007). Under this paradigm no singular truth is perceived to exist but rather multiple perspectives. This contrasts firmly with the positivist paradigm with its underlying belief in a single objective reality. Constructivists argue that positivist claims about 'truth' and 'objectivity' should be questioned, and acknowledged as only one perspective (Gergen 1999). The focus of constructivism is not therefore on generalisation or the gaining of universal truths, but rather on gaining an understanding of how individuals talk about their experiences and the meanings they associate with particular events. When individuals associate meaning to events they construct the experience (Saks & Allsop 2007).

As outlined earlier, the focus of this study was to gain an understanding of how older people and their informal carers perceived the whole experience of the AMU stay and receiving the RCT intervention. The aim was to hear the multiple voices of older people and their informal carers regarding their experience. The constructivist paradigm holds that both patients and their informal carers will recall pertinent events from such experiences, and then constructively add details, take away details and transform details. In this way they are effectively creating the experience (Holstein & Gubrium 1997). Each and every person will thus provide a unique construction of the experience, and as such, no one unequivocal construction can be truly identified. One could argue therefore that such research is futile, as no single construction can be established. However it is recognised in the literature that the triangulation process of capturing multiple perspectives does enable the researcher to arrive at some consensus (Guba 1990). Although each and every interpretation of an event or experience is individual, these constructions are not just a product of an individual's mind. The theory is that the constructions of the research sample will be influenced by their shared historical and cultural

influences. Hence patterns can emerge from their constructions. Also these constructions will be influenced by their interactions with others. So although people all see different things, what they see is in fact determined by their social and cultural influences, and presuppositions. Age, gender, class, ethnicity, history and personal interests will all affect how people perceive and construct events (Etherington 2004, Gergen 1999, Moses & Knutsen 2007, Underwood et al 2010).

Having stated that the ontological position of the study stemmed from the constructivist paradigm, it is important to clarify here that an extreme form of constructivism was not adhered to. Miles and Huberman (1994) acknowledge that a stereotypical continuum exists in research between constructivism at one extreme and positivism at the other. They go on to state however that it is rare for researchers to be firmly encamped at one extreme or the other. In fact a middle ground of constructivism informed this study. This acknowledges that physical illness and disease, such as those experienced by older patients presenting to AMUs does physically exist (Saks & Allsop 2007). However as a constructivist study the interest was focused on the subjective element of the AMU experience of older people and their informal carers.

Ideology

Researchers frequently adopt an ideological perspective when conducting qualitative investigations (Creswell 1998). A postmodern ideological perspective informed this study, and complemented the underlying constructivist ontological perspective. Postmodernism is influential in many fields of intellectual discourse, including the natural and social sciences, the humanities, art, literature, journalism and politics (Rosenau 1992). Amongst other things postmodernism questions the power relations embedded in the representations and constructions of social reality (Silverman 2001). Postmodernism, consistent with constructivism, is sceptical about the whole notion of truth. Rather truth is perceived as multiple, historical, contextual, contingent and political and, importantly bound up in power relations (Patton 2002). Whilst constructivists recognise that for any given situation there are multiple descriptions and thus knowledge is multiple, postmodernists argue that knowledge, although multiple, is in fact privileged to those in positions of power.

Postmodernism challenges the monopoly of truth which is legitimised by those in positions of power. In so doing it recognises the partiality of truth (Rosenau 1992).

The healthcare system in the UK is dominated by the medical model, the discourse of which rests on a positivist paradigm. Positivism emphasises objectivity, measurement, and quantification. Within healthcare there is belief in the 'typical' patient, who can complete standardised instruments (Silverman 2001).

Consequently positivists speak of numbers and statistics. The individual is overlooked in the quest for universal averages. Postmodernism disputes the modernist belief, espoused by positivism, that there are universal and generalizable explanations. It thus rejects grand theories which seek to provide explanations and instead favours multiplicity and plurality. 'Truth' is perceived as multi-layered and multi-dimensional and therefore no single representation of a healthcare system can capture the 'truth' about its care or practice (Cheek 2000).

Creswell (1998) states that knowledge claims and discourses are dominated by those in positions of power and control within society's hierarchies, such as those existing within the field of healthcare. It is recognised that, within this field, those in positions of power are the healthcare professionals. A power relationship exists between healthcare professionals and their clients through a process of 'mystification'. The knowledge of healthcare professionals is claimed as the 'truth', and as this knowledge operates beyond everyday common sense, it creates social distance between the professionals and the recipients of their interventions (Johnson 1982). Foucault famously argued that knowledge is inextricably bound to power, and that knowledge provides a power base for professional groups (Cheek 2000, Abbott & Meerabeau 1998). By privileging the 'truth' of those in power, the voices of others, particularly those in marginalised groups, are not heard (Gergen 1999).

Postmodernism is about raising awareness of the different discourses that exist within society, especially those from marginalised groups (Creswell 1998). The focus is therefore especially on the marginal and the silenced (Rosenau 1992). Marginalised groups often lack a voice in the acute medical environment, whereas stated above, power is situated with the healthcare professionals. Koch (1998) identifies older people as a marginalized group in developed countries. Unlike

those societies, where older people are valued for their knowledge and wisdom, in developed countries older people are frequently 'written off'. They are often portrayed negatively in the media, as non-contributors and as a social problem and burden. British society, like many developed countries, is geared towards youth, and remaining young, and it has been recognised in these societies that discrimination and prejudice exists towards older people, be it in healthcare, employment, or other fields (Tinker 1997).

Discussion of old age in healthcare is frequently both negative and pessimistic. Older people are often perceived as frail with their illnesses seen as a natural part of getting old. Their disabilities gradually erode their physical and cognitive abilities, and they become dependent on others (Tinker 1997). When experiencing an acute illness requiring hospitalisation, the older person is faced with an unfamiliar clinical environment, where they are dependent on the hospital staff to address their needs. In this situation the imbalance of power between the patient and healthcare professional is considerable (Sorlie et al 2006). Research is often professionally orientated and there is relatively little research around hearing the voice of those on the receiving end of acute healthcare (Richardson et al 2007, Shatell et al 2005, Watson et al 1999).

Within a postmodern ideological perspective it is considered important to give older people a voice through research. This provides a means of raising awareness for healthcare professionals about what it is like to be a patient. It has been recognised that changing the way that healthcare professionals think, through publication and presentation of research, can lead indirectly to transformation of experience for marginalised groups, such as older people (Koch 1998).

Research Design

The constructivist paradigm underpinned the entire study. The following were adopted:

- A relativist position, that is, a belief in multiple realities.
- A subjective epistemology. The very essence of constructivism is that reality only exists in the mind of the participant, and thus the only way of accessing individual constructions is through subjective interaction (Guba 1990).

- A naturalist methodology, more specifically, an interpretive narrative methodology.

Methods

Interpretive narrative methodology was the chosen methodology for the study because of its potential to redress some of the power differentials already recognised as inherent in medical research (Elliott 2005). Through inviting narratives the interviewee and interviewer relationship is subtly transformed, to one of the narrator and the listener. Each has an equally important role as storyteller and listener (Blythe et al 2013). It has been recognised in the literature that in-depth interviews, specifically narrative interviews, are the favoured approach when exploring the complex and nebulous nature of care (Holloway & Freshwater 2007, McCance et al 1997). The narrative interview was therefore the methodological tool selected to gain access to the stories of older patients and their informal carers. The interview questions in this method are designed to encourage the telling of stories, rather than the more traditional question and answer responses of interviews. Consequently the interview questions are broad and restricted to a small number, so as to encourage the natural flow of narratives (Holloway & Freshwater 2007). Importantly, this method encourages the narrator to assume responsibility for choosing the stories that they tell and for making the point behind those stories (Chase 2005). This method enables patients to make judgements about the aspects of care and treatment that they wish to share with the interviewer (Holloway & Freshwater 2007, McCance et al 1997).

It has been identified in the literature that through listening to patient stories we can capture knowledge lost through more structured research approaches (Simpson et al 1995). The knowledge sought through these approaches is frequently predetermined by the institutions and professionals conducting the studies. Stories on the other hand provide a means of hearing the multiple voices of those in the receipt of the care provided by these institutions and professionals. Stories give people a voice, especially those from marginalised groups (Blythe et al 2013, Koch 1998).

Importantly narratives are constructed, and as such fit comfortably with the underlying ontological paradigm of the study. Narrative methodology has been

recognised as the constructivist methodology of choice (Moses & Knutsen 2007). It is recognised in the literature that humans understand and express their daily lives through a storied world and, as such, it is a natural impulse to tell stories (Blythe et al 2013, Etherington 2004, Gergen 1999). Importantly stories elicited for research demonstrate how life events affect people and how these events are given meaning by participants (Blythe et al 2013). Hence through the telling of stories patients can make sense of their hospital experience (McCance et al 2001). Even in today's evidence based health care it has been recognised by healthcare professionals that patients still make sense of their medical experiences through the stories they tell (Elwyn & Gwyn 1999). Humans construct stories and, in the process, they reaffirm their experience, modify it and even create new experiences. Thus narrating experience is actually a creative process in which the narrator and 'reality' are reborn (Frid et al 2000). Although stories depend upon the subjective perspective of the individual story-teller, they are also linked to the cultural knowledge of the narrator and are thus socially constructed. In this way stories provide a cultural and shared perspective of care and treatment.

By focusing on narratives the intention is not on ascertaining the 'truth', but rather on determining the meaning conveyed in the story (Hill Bailey & Tilley 2002). Qualitative researchers who analyse narratives recognise that narratives are reconstructions of the events described; and as such do not portray facts or truth of accounts, but rather the meaning conveyed in the story (Hill Bailey & Tilley 2002). It is argued in the literature on narrative that it is unnecessary to even assume the narrator is providing an objective and truthful account of the event. Rather the emphasis is on how the story reflects the narrator's interpretations and values. It is accepted therefore that narratives do not transparently reflect experience. Rather narratives give meaning to events and experiences (Elliot 2005).

Part Two: Data Collection

This section of the chapter focuses on the practical gathering of the data for the study.

The Interview Guide

To encourage participants to provide narratives, an interview guide was designed. Its aim was to elicit stories around the participant's acute illness experience in relation to their AMU stay. The focus of the interview guide was primarily on encouraging narration, but as outlined earlier as a practitioner researcher there were obligations to meet around the overall aims of the RCT process evaluation. This evaluation necessitated that participant opinions and views were elicited over and above the narration. To this end the interview guide included prompts to encourage both narration and opinions/views.

Riessman (1993) recognises that narrative questions can be combined in the same interview with other types of questioning and that this is often the case when students have to combine their own needs with those of departmental expectations. In the interview guide the narrative questions preceded the opinion eliciting questions, in an effort to encourage participants to open up to narrative conversation. The interview guide encouraged narratives around the following stages of their acute illness:

- The pre-admission stage
- The hospital stay stage
- The discharge stage
- The resettlement home stage

Each stage included prompts and probes to encourage further narration. These prompts were considered necessary as it is recognised that interviews have certain social expectations, which includes turn-taking rules (Mishler 1986). This may discourage participants from taking up more than the time usually allocated in turn-taking conversation compared to that required when giving narratives (Labov 1997). The interview was then funnelled down to encourage the participants to give their views and opinions about each stage, in line with the needs of the process evaluation.

The plan was to interview, where possible, patients and carers separately, to gain their individual perspectives. Hence two separate interview guides were designed (see Appendix 2a).

Sampling

The sample for the study was to be drawn from the East Midlands RCT population. Those in the population met all three of the following criteria:

- Patient participants aged 70 years or over
- Patient participants discharged from the AMU within 72 hours of attending the hospital
- Patient participants identified at risk of re-admission (i.e. those having a score of two or higher on the Identification of the Seniors at Risk score)

Note: In line with the Mental Capacity Act (DH 2009) consultee consent was to be obtained for patients without capacity either from the informal carer or from the registered medical practitioner responsible for the patient's care.

It excluded:

- Patients resident outside of the hospital catchment area
- Patients whom the AMU staff cited as inappropriate to recruit (e.g. the patient was aggressive, disturbed, or unable to communicate)

The plan was to purposively select a smaller sample from this population. Qualitative sampling is different to quantitative sampling. The aim of the latter is to choose individuals that are representative of the population, so that ultimately the findings can be generalised to the overall population (Creswell & Plano Clark 2007). Conversely the aim of qualitative research is to procure, from smaller samples, rich and detailed data which illuminates the phenomenon under investigation (Koch 1998). To achieve this illumination, patient participants were to be purposively selected from those patients who had experienced both a stay on the AMU and received the interface geriatrician service. The purposeful strategy of maximum variation sampling was to be adopted. The aim of this was to select a range of participants who held different perspectives. Participants were to be chosen on the basis of each being different from the other, and therefore their

views should theoretically reflect this difference, providing a sound qualitative study which is not biased by one sided opinions (Creswell & Plano Clark 2007).

To ensure the selection of a diverse patient sample the following attributes were to be sought:

- Patient participants from both genders
- Patient participants from different ethnicities (available within the population)
- Patient participants across a spread of ages between the “younger old” (70 years to 84 years) and “older old” (85 years and over). The latter group has been recognised as those most likely to need help with their ADLs (Age UK 2014, DH 2008b)
- Patient participants admitted for a range of reasons
- Patient participants with different dependency levels, determined by a range of Barthel scores (Mahoney & Barthel 1965)
- Patient participants being supported by a range of informal carers (spouses, children, siblings, friends or neighbours)
- Patient participants with different levels of re-admission risks, determined by a range of Identification of Seniors at Risk scores (McCusker et al 1999)
- Patient participants with different residency status (either living alone or with another)

Exclusion criteria:

- Patient participants without capacity (excluded as a result of concerns raised by the University Ethics Committee). Under the Mental Capacity Act (DH 2009) research that can be undertaken as effectively with people who have capacity should exclude participants who lack capacity.

The plan was to interview a sample of up to 15 patient and 15 carer participants, using the above attributes to ensure a varied sample. The size of the sample was based on other qualitative studies which have explored the patient perspective and experience of hospital care (Eriksson et al 2009, Hill Bailey & Tilley 2002, Nakano et al 2008). From this sample, a smaller sub-sample of up to six patient and six carer participants was to be selected for a more in-depth analysis on just the narrative component of the interviews. Once again the size of this sub-sample was

determined by the size of other narrative studies (Kelly & Howie 2007, McCance et al 2001). It is recognised in the literature that a smaller sample is required when analysing narratives due to the more in-depth nature of this type of analysis (Chase 2005, Hill Bailey & Tilley 2002, Koch 1998, Riessman 2008). The participants for this sub-sample were to be selected from those providing the greatest number and depth of narratives.

Pilot Testing

The first two interviews were to act as a pilot. This was considered particularly important because of the combined use of narrative and opinion/view type questions in the interview guide. As such this approach was untested. Pilot testing is recognised as a means of both testing the feasibility of questions and improving the interview guide (Polit & Hungler 1997).

Patient and Public Involvement (PPI)

PPI is about actively involving members of the public in research. Members of the public are defined as patients, potential patients, carers and people who use healthcare services (National Institute for Health Research, NIHR 2014). PPI involvement in research is important because patients and the public have personal knowledge and experience of using health care services, and may have valuable views about what should be researched and in what way. PPI may strengthen the design of studies and it is good practice to involve the public as early as possible in health and social care study design (NIHR 2012). Furthermore it is recognised that there are important distinctions between the perspectives of the public and those of healthcare professionals (NIHR 2014).

The protocol, participant information sheets, consent forms, and interview guides were reviewed by a carer representative who was experienced in reviewing research protocols, and sat on several research steering groups. This carer is an older person with several years of experience providing 24 hour care for his wife. More recently he had experienced a minor stroke, and spent two days at the hospital where the study was being conducted. He reported that he had spent nearly eight hours on the day of his discharge awaiting medication, and had returned home only to find that his general practitioner had not been informed of alterations to his medication.

This PPI representative made several comments and suggestions about the protocol as well as the patient and carer participant information sheets so as to make the wording plainer. He also advised about the timing of the interviews in relation to the discharge date, as he believed that participant's ability to recall events would reduce if interviews were conducted too long after discharge. As a consequence of the PPI consultation it was initially decided that the interviews would be conducted within four to six weeks of discharge.

Ethical Approval

Ethical approval was gained from both the NHS Research Ethics Service and the University of Salford College of Health and Social Care Ethics Committee.

The study was to be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki (1996), with the principles of Good Clinical Practice (GCP), and the Department of Health Research Governance Framework for Health and Social Care (2005) (National Institute of Health Research Clinical Research Network 2010).

Recruitment

Recruitment commenced once ethical approval had been received, and took place over a 12 month period (February 2011 to February 2012) to coincide with the data collection stage of the RCT. Patient participants were verbally informed of the study by Research Assistants during the RCT recruitment, and asked if they might potentially be interested in taking part in a post-discharge interview. The details of those participants expressing an interest were forwarded to me by the RCT team. Participants were then purposively selected from these details. The selected participants were telephoned two weeks following their discharge, to determine if they might still potentially be interested in taking part in an interview. This two week time lapse was provided before making contact with the participants to provide them with sufficient time to settle back home. At the same time, those participants, with an informal carer in the RCT, were also asked if their carer might be interested in taking part in an interview. Those patients (and their informal carers, if any) who expressed an interest in participating were sent a participant information sheet/s on the study (see Appendix 2b). Patients (and their informal carers) were given a minimum of a week to read through the participant information sheet/s. Participants

were then telephoned to confirm that they had read the participant information sheet in full and understood it, and were asked whether they still wished to take part in an interview. Where interest was expressed an interview date was then set.

Sample Achieved

Thirty four patient participants were purposively selected from the details of those forwarded to me from the RCT team. From these 34 patients, 21 expressed an interest in taking part in the study. Two of these however were then re-admitted before interview and another was not available during the required time frame (of less than 6 weeks post-discharge). The final number of patient participants was 18, which exceeded the original plan of 15 patient participants for reasons explained later in the Ethics Amendment section (see page 48). Reasons for non-acceptance included being too unwell, or simply not wanting to take part. There was no demographic difference between those in the sample and those not interviewed.

The final achieved sample of 18 patient participants included: Ten women and 8 men, and all were of white British ethnicity. The absence of any other ethnic minority groups was attributed to the low number of these in the RCT population. There were only seven patients from an ethnic minority group in the RCT and only one of these patients had mental capacity. However this patient was re-admitted to hospital and consequently was not available for interview.

The patients in the sample were aged between 74-89 years. Ten of the patients lived alone, seven lived with a spouse, and one lived in a care home. The patients presented with a range of admission reasons. One problem experienced when selecting patients for the sample was the high independence level of the RCT population. Overall the patients in the population had high Barthel scores, suggesting that patients were largely independent with their basic ADLs prior to admission. Despite trying to select patients with a range of Barthel scores, only three patients scored less than 16, out of a maximum of 20, on the Barthel score (Mahoney & Barthel 1965). Likewise the RCT population scored low on re-admission risk. Once again despite trying to select patients with a range of Identification of Seniors at Risk (ISAR) scores, only five patients scored four or five, out of a maximum of five, on this assessment tool (McCusker et al 1999). The demographic data of the patient participant sample is provided over the page.

Table 1: Patient Participant Sample

ID	Age	Gender	Ethnicity	Residency status	Barthel score	ISAR score	Admission reason
Annie	78	F	W	Lives with partner	19	3	Collapse
Leonard	87	M	W	Lives with wife	20	2	Abdominal pain
Grace	79	F	W	Lives with husband	18	3	Haematomasis
Beryl	80	F	W	Lives alone	19	4	Chest pain
Charles	74	M	W	Lives with wife	12	3	Swollen leg
Kath	88	F	W	Lives alone	20	4	Shortness of breath
Albert	78	M	W	Lives with wife	16	3	Chest pain
David	80	M	W	Lives with wife	20	3	Diarrhoea
Ida	88	F	W	Lives alone	17	3	Fall
Doris	81	F	W	Lives alone	20	2	Exhaustion
Norman	76	M	W	Lives alone	12	3	Back pain
Barry	77	M	W	Lives alone	20	2	Chest pain
Malcolm	89	M	W	Lives in care home	16	4	Fall
Norma	80	F	W	Lives alone	18	2	Chest pain
Edna	89	F	W	Lives alone	18	2	Dizziness/fall
Freda	81	F	W	Lives with son	3	5	Vomiting
Jean	83	F	W	Lives alone	18	5	Heart racing
Jake	87	M	W	Lives with wife	17	3	Shortness of breath

Note : All names are pseudonyms.

High Barthel scores denote greater independence with basic daily living activities. In contrast higher ISAR scores denote greater risk of functional decline

Of the 18 patient participants, eight identified an informal carer, and these were invited for interview. This achieved a final sample of six carer participants (five women and one man). Reasons for non-participation included a preference not to take part and refusal by one patient participant for their carer to be interviewed.

The declining carers stated that they did not provide any direct care for the patient participant. This was in contrast to the carers interviewed who stated that they

provided care on a daily basis for the patient participants. The carer participants were either the children or spouses of patients. There was an even mix of support provided by these carers. Details on the carer participant sample are provided in the table below.

Table 2: Informal Carer Participant Sample

ID	Relationship of informal carer	Lives with patient participant	Level of informal carer support	Home care assistance
Clare	Daughter to Beryl	No	Domestic tasks	No
Betty	Wife to Charles	Yes	Personal & domestic tasks	Yes
Jane	Daughter to Kath	No	Personal & domestic tasks	No
Keith	Son to Freda	Yes	Domestic tasks	Yes
Diane	Daughter to Jean	No	Domestic tasks	Yes
Vera	Wife to Jake	Yes	Personal & domestic tasks	No

Note: All names are pseudonyms

Data Collection

The plan was to conduct the interviews within four to six weeks of discharge. It was anticipated that this time frame would enable participants to have time to settle back home post discharge, have exposure to the interface geriatrician service and yet be soon enough after discharge to minimise potential problems of recall of the AMU experience. However memory recall was found to be an issue during the data collection, and thus an ethics amendment was submitted to interview participants sooner after discharge (see Ethics Amendment section, below).

Two pilot interviews were conducted, one with an individual patient participant, and one with a patient alongside their carer. No alterations were made to the interview guide as a result of the pilot testing, and consequently the data from these two interviews was included in the final analysis.

The plan had been to interview patients and carers separately, however in reality, all the patients requested that their carer was interviewed alongside themselves so

the two interview guides were combined. The patients and carers were therefore asked the same questions. However questions directed at the carers were focused on how the acute illness episode had impacted on them, and whether they were providing more care. If this was the case, they were asked how this had impacted upon their daily lives, and whether they had any additional commitments.

A total of 18 interviews were completed (including the two pilot interviews), composed of 12 individual patient interviews and a further six patient interviews which were conducted alongside six carers. These interviews ranged in length from 15 to 100 minutes, with a typical length of around 40 minutes.

All the interviews were conducted in the patient participants' homes. As I was working alone in the community, I followed the University's Lone Researcher Policy. This necessitated that a named member of staff was informed of the time, location, and expected duration of interviews, and they were informed when I left the home of each participant.

At the start of every interview it was ensured that the patient participant (and carer) had indeed read their participant information sheet/s and the participants were provided with the opportunity to ask any questions or seek clarification of information. They were informed that taking part in the study was entirely voluntary, and that they were free to withdraw at any point without giving a reason. They were also informed that any information provided would be kept strictly confidential, and that their name and personal details would be removed from this information so that they could not be identified. All participants signed a written consent form for the study. This included consent to audio record the interviews (see Appendix 2c). However if participants provided relevant details before or after the audio recording they were also asked if these comments could also be included in the study. The participants were informed of the approximate time required to complete the interview, and it was requested where possible, that the interview was completed in a quiet room away from any interruptions. The participants were asked at the end of the interview if they would be interested in receiving information on the findings of the study.

Transcription

All the interviews were transcribed verbatim. The initial aim was that I would personally independently transcribe all of the interviews. This decision was made on the basis of recommendations in the literature. This literature recognises that transcription is more than a trivial and mechanical task and should be considered as part of the analytic process (Elliott 2005). Delegating transcription leaves 'fingerprints' on the transcripts and adds distance between the researcher and participant (Tilley 2003). Hence by transcribing the data independently, it was anticipated that I would remain close to the data, which was something that I perceived as important. However for practical reasons (time and sick leave) this was not always possible. A total of 13 transcripts were self-transcribed. The remaining transcripts were transcribed by clerical workers experienced in transcription. Where interviews were transcribed by another, I read these transcriptions alongside listening to the audio files and made any necessary corrections. In this way I felt that I still remained close to the data.

The transcripts, consent forms and audio files were stored in a locked filing cabinet in a secure office, and participant identification details were kept separately from the transcripts.

Ethics Amendment

A substantial amendment was submitted to both ethics committees toward the later stage of the study. This was in response to three issues:

- i) On achieving the sample size of 15 patient participants, there was concern that the sample was heavily populated by patients with high Barthel scores (high independence level) and low ISAR scores (low re-admission risk). A request was therefore made to continue recruitment, enabling further patients to be selected if they had either low Barthel scores and/or high ISAR scores. This resulted in the recruitment of a further three patients, giving a total sample size of 18 patient participants.

- ii) There was a low number of carer participants in the sample. Consequently a request was submitted to interview informal carers not part of the RCT. This was because when going out to interview patient participants, there were occasions when their informal carers asked to take part in the interviews, even though they were not taking part in the RCT. It was often the case that the patients wanted these informal carers present and taking part in the interviews. This seemed an appropriate way of gaining the carer voice.
- iii) Memory recall problems were found to be an issue during the data collection, and a request was therefore submitted to interview patients earlier, within two weeks, instead of four to six weeks post discharge.

A favourable opinion for the above three requests was obtained from both committees.

Part Three: Analysis of Data

This section of the chapter focuses on how the collected data were analysed and interpreted.

Data Analysis

As the interview guide consisted of both narrative and opinion eliciting questions the data required two different types of analysis: narrative and thematic analysis. The former was employed to analyse participants' narratives, and the latter to analyse participants' opinions and views. It was anticipated that there would invariably be some cross over between these two types of data, yet by using narrative and thematic analysis, all of the meaning within the data should be captured by one or both of the analytical approaches. Regardless of the type of analysis, an inductive approach was to be adopted to examine the issues of importance raised by the participants.

According to Coffey and Atkinson (1996) qualitative analysis is about being flexible and artful rather than adhering to a rigid set of rules. As such they recommend exploiting a variety of analysis approaches, emphasising that much can be gained from trying out different analytic angles on one's data. They state that using different analytic approaches can generate new insights and helps to prevent the analyst from adhering rigidly to the most obvious and, potentially ill-founded, conclusions. Miles and Huberman (1994) warn that researchers, especially when working alone, are at risk of reducing reams of information into selective and oversimplistic categories. Using two analytic approaches enables lone researchers to look at their data in an alternative way, justifying the conclusions drawn, and identifying any weaknesses in their findings.

Although constructivism underpinned the study, I did not subscribe to the extreme form of constructivism, which holds that there is no unambiguous social reality (Miles & Huberman 1994). By planning two different analytic methods I sought to approach the data from two different angles, stimulating consideration of new ideas, and reducing the risk of data just being poured into a 'given theoretical mould' (Etherington 2004 pg 20).

Field notes were completed immediately after each interview and these were utilised in the analysis process. This involved personal reflection upon my own perceptions and constructions, as it was recognised that ultimately the findings of the study would be influenced by the constructions of both the participants and my own constructions (Guba 1990). (See Chapter Five, Reflexivity).

In keeping with the wish to remain close to the data, a decision was made to analyse the data manually rather than utilising a computerised software package. Webb (1999) has argued that qualitative analysis is a creative process and as such cannot be reduced to a mechanical process; thereby favouring manual methods over computerised processes.

Data Analysis Procedure

The following section of the chapter is divided into two parts. The first part (Part A) details the thematic analysis and the second part (Part B) the narrative analysis. The analysis is presented in this order in keeping with the order that it was completed. The thematic analysis was completed first as it necessitated the analysis of all 18 transcripts (comprising 12 individual patient interviews and six paired carer-patients interviews). The repeated reading and re-reading of the 18 transcripts, as part of the thematic analysis process, lead to the identification of just six transcripts that were infused with narratives. These were from three individual patient interviews and three interviews where the patients were interviewed alongside their carers. These six patient participants and three carer participants were therefore selected for the smaller sub-sample upon which the narrative analysis was undertaken.

The practical process of completing the two analytic methods is detailed below. Each analytic method is sub-divided into two sections: i) the choice of analysis approach, and ii) the actual approach followed.

Part A: Thematic Analysis

i) Choice of analysis approach

The plan for this part of the analysis was to complete a broad level of analysis over the entire data set (i.e. an analysis on all the patient/carers transcripts), to address

the 'opinion generating' questions in the interview guide. Thematic analysis was the analysis approach selected for this stage of the analysis.

Thematic analysis is a process which spans a whole range of qualitative traditions, and is often used by qualitative researchers. It is referred to by many different names (Boyatzis 1998), and actually is rarely acknowledged in the literature as "thematic analysis" (Braun & Clarke 2006). For example, Saks and Allsop (2007) refer to the process as thematic content analysis, whilst many modified versions of grounded theory make use of thematic analysis techniques. Thematic analysis, although widely used, is poorly demarcated in the research literature (Braun & Clarke 2006). It is difficult therefore to find detailed reference to the technique. However, as a process, it forms the foundation of many qualitative analytical methods (Braun & Clarke 2006). Additionally because thematic analysis is so flexible, and used across so many qualitative traditions, it is not tied to any one theoretical or epistemological position. As such, it is compatible with the constructivist paradigm underpinning this study (Braun & Clarke 2006).

ii) Analysis approach followed

Consideration was given as to how to complete a thematic analysis in practice. Braun and Clarke (2006) recognise that there is an absence of clear and concise guidelines on thematic analysis, and have subsequently devised a 'recipe' for the process. Their model provides a clearly demarcated guide, which is both systematic and methodological. Their six phase model can be easily communicated and understood by others, and as such can be easily disseminated in research papers. The use of a clear model also enables the researcher to be open and transparent about how large amounts of raw data are interpreted and developed into findings, and ultimately this facilitates the replication of qualitative studies. The work of Braun and Clarke (2006) provides a clear structural model of analysis, and for this reason the model was adopted for the thematic analysis.

All 18 transcripts (representing the views/opinions of 18 patients and six carers) were analysed using Braun and Clarke's (2006) six phases:

Phase One: Familiarisation with the data:

This phase required listening to all the 18 audio files and jotting down initial ideas. The whole process of familiarisation was then continued by reading and re-reading the 18 transcripts, and through reading all the field notes. Once again this involved active listening, and noting down ideas. This was a lengthy process but considered necessary to ensure full immersion into the data.

Phase Two: Generation of initial codes:

The second phase required assigning codes to the data. Codes are features of the data which present as being of interest to the analyst (Braun & Clarke 2006). As such they are the most basic segment of the data. This phase required coding anything of interest and resulted in the identification of 260 codes (see Appendix 2d). The data were coded inductively and where any doubt existed the data were coded, working on the assumption that it is easier to discard data later, rather than to recode.

A manual process was used to code each transcript, which involved using highlighter pens and writing on the transcripts. This was a very time consuming process but necessary to keep close to the data. This was not a linear process, as each time a new code was identified it necessitated going back to check earlier transcripts in which the code may have been missed. This was also a slow and meticulous process but it aided immersion into the data. The data extracts were then copied electronically and pasted under the relevant codes in separate files. It was felt that the use of a computer package at this stage might have resulted in lost data as such software cannot pick out the hidden meaning behind participant words. Having coded every transcript it was then necessary to return to read through all the transcripts one final time to ensure all data had been coded.

Phase Three: Search for potential themes:

Phase three required identification of potential themes from the coded data. All thematic analysis techniques, regardless of the process employed, are characterised by the identification of themes within the data (Boyatzis 1998, Braun & Clarke 2006, Saks & Allsop 2007). In other words, all methods employing thematic analysis share the characteristic of searching for patterns or similarities

across the entire data set (Braun & Clarke 2006). It is important to note here that identifying themes is an active process of construction. Themes do not just emerge passively out of the data. This phase of the analysis involved collating the data codes (along with their corresponding quotations) into potential themes. This was achieved by collapsing and clustering codes that cohered around shared features. Codes that cohered together around a central idea were clustered to form a potential theme. Where potential themes were large and complex they were broken down into sub-themes; thereby providing structure and a hierarchy of meaning within the data (Braun & Clarke 2006).

An example of codes that were clustered together to form a potential sub-theme is provided in the appendix (see Appendix 2e).

This phase of the analysis ended with a collection of coded chunks of data collated around potential themes and sub-themes.

Phase Four: Reviewed themes:

This next phase required reviewing the coded chunks of data with their corresponding theme to ensure a comfortable fit. To help with this and to be clear about what each theme represented, a statement was written as a descriptor. It was important at this phase to ensure there was sufficient number and/or quality of data chunks to justify a theme. Once all the coded chunks of data had been read and reviewed it was necessary to return to the entire data set, and re-read all the transcripts. The overall objective here was to ensure that the potential themes provided a sense of the predominant and important issues raised by the participants across the data set.

There is debate in the literature around the prevalence of data required to constitute a theme. Braun and Clarke (2006) point out that the issue is not about quantification but rather about the importance and value placed on observations by the participants. Overcash (2003) offered two criteria for identifying a theme: firstly, repetition (i.e. observations are repeated) and secondly, forcefulness (i.e. the importance of the observation to the participant). Regardless of how themes are identified, Braun and Clarke (2006) recommend that the researcher adopts a systematic and consistent approach. To this end a decision was made to follow the guidance by Overcash (2003), and it was thus determined that a potential theme

would only be constructed into a definitive theme if it was a patterned response (i.e. repeated), and/or perceived as important by participants (i.e. forceful: a strong or moderate response was made).

Phase Five: Defined and named definitive themes:

The fifth phase required defining the final themes; thereby identifying the very essence of what the data in each theme captured. Once defined, each theme was given a succinct, concise and informative name, providing the reader with a quick and easy handle on the data. Each and every theme told a story, but like a jigsaw, the themes fitted together to provide a broader overall story (Braun & Clarke 2006).

Phase Six: Production of the thesis:

Once phases one to five were completed the final phase necessitated the dissemination of the findings (in this case via the thesis) to others.

Part B: Narrative Analysis

i) Choice of analysis approach

The plan for this part of the analysis was to complete a deeper level of analysis with a smaller sub-sample of participants to address the narrative questions in the interview guide. Narrative analysis was the analytical method selected for this part of the analysis. The value of a second analytic method over and above thematic analysis has been recognised in the literature (Williamson & Long 2005).

The sub-sample for the narrative analysis was to be identified through the immersion process of the earlier thematic analysis. A maximum sample of six patient and six carer participants was planned for this part of the analysis. The sample was to be identified through transcripts which were rich in narratives (in terms of length and degree of detail).

In practice it was found that most of the participants used little in the way of narratives in their responses, despite the narrative questions and prompts/probes in the interview guide. There were six clear transcripts which provided lots of detailed narratives, and these six transcripts were selected for the more detailed narrative analysis. These six transcripts were taken from three individual patient interviews, and three interviews where the patients were interviewed alongside

their carer. Thus the narratives are from a sample of six patients and three carer participants. These participants are identified in the table below.

Table 3: Analytical Process per Participant

Patient No:	Carer No:	Participant ID:	Analytical process
1		Annie	Narrative & Thematic Analysis
2		Leonard	Narrative & Thematic Analysis
3		Grace	Narrative & Thematic Analysis
4	1	Beryl & Clare (Daughter)	Narrative & Thematic Analysis
5	2	Charles & Betty (Wife)	Narrative & Thematic Analysis
6	3	Kath & Jane (Daughter)	Narrative & Thematic Analysis
7		Albert	Thematic Analysis
8		David	Thematic Analysis
9		Ida	Thematic Analysis
10		Doris	Thematic Analysis
11		Norman	Thematic Analysis
12		Barry	Thematic Analysis
13		Malcolm	Thematic Analysis
14		Norma	Thematic Analysis
15		Edna	Thematic Analysis
16	4	Freda & Keith (Son)	Thematic Analysis
17	5	Jean & Diane (Daughter)	Thematic Analysis
18	6	Jake & Vera (Wife)	Thematic Analysis

Note: All names in the table are pseudonyms

ii) Analysis process followed

Similar to thematic analysis, a review of the narrative literature revealed that despite a diverse range of narrative frameworks there is little clear guidance on how to practically complete a narrative analysis (McCance et al 2001). One model, by Labov and Waletzky (Structural Model of Narrative Form 1967) stands out in this literature, because it offers a structured, methodological and systematic approach to analysing narratives. This model is widely cited in the narrative literature and provides a socio-linguistic perspective of narratives. Labov and

Waletzky extensively studied narratives from hundreds of individual and focus group interviews, and from their work concluded that narratives are a specific form of discourse which is characterised by certain structures (Chase 2005). They stated that all narratives, regardless of their content, include a structure which includes four core, and two optional components. The researcher can use this model to break down narratives and to identify the meaning behind each narrative.

This model was adopted to analyse the narratives identified in the six transcripts. The four phases of the model are outlined below:

Phase One: Identify narratives:

Narratives were identified from the text. There is considerable disagreement on the definition of narrative in the literature (Riessman 1993). For the purpose of the study a narrative was defined according to Labov and Waletzky (1967): A story must have a clear beginning, middle and end, be about a specific past event, and contain the core components of Labov and Waletzky's model (see Phase Two below).

What became apparent when reading through the narratives was that those participants who spoke in narrative form did not confine their narratives to the AMU experience. Rather they narrated events across their entire illness experience and life course. This was in marked contrast to those participants whose interviews lacked narrative. It is recognised in the literature that one strength of focusing on narratives, is that they are chosen by the participant and not by the researcher, and as such narratives inform the listener of the participant's own personal reality (Borjeson et al 2010). Narratives may thus be simply a brief and temporally ordered story in response to an interviewer's question (i.e. the AMU experience), or they may be an extended turn at talk which includes flashbacks to past experience (Riessman 2008). The latter was considered relevant and consequently a decision was made to include all narratives related to the illness experience, as previous experience impacts on present experience.

Using this definition of a narrative, 73 narratives in total were identified. The distribution of narratives across the transcripts is portrayed in the table over the page. Any non-narrative material was discarded at this point.

Table 4: Distribution of Narratives

Participant ID	Number of Narratives
Annie	9
Leonard	10
Grace	15
Beryl & Clare (Daughter)	11
Charles & Betty (Wife)	21
Kath & Jane (Daughter)	7

Note: All names in the table are pseudonyms

Phase Two: Parse narratives:

Each narrative was parsed according to Labov and Waletzky's Structural Model of Narrative Form. This is detailed below:

Narratives were broken down into the four core components of the model (and the two optional components where present):

- Orientation: This part of the narrative provides the background, including the time, place and persons implicated.
- Complicating Action: This part of the narrative provides the event sequence, revealing a turning point, crisis or problem.
- Evaluation: This part of the narrative suspends the action of the narrative and provides the point of the narrative.
- Resolution: This part of the narrative reveals how the event finished.

Two optional components:

- Abstract: This provides a summary of the narrative.
- Coda: This returns the listener to the present moment.

The most crucial component of the model is recognised as the Evaluation component. Cortazzi (1993) states that participants give their perspective in this component, and evaluate the meaning behind the narrative. It is a natural and even unconscious part of narration. It provides the soul of the narrative and is infused with the perspective, meaning and value that the event held for the participant (Riessman 1993). The presence of the evaluative function is imperative when it

comes to the analysis of narratives. Basically, when giving a narrative, individuals stand back from the action and provide an evaluation. This is the key focus of Labov and Waletzky (1967) Structural Model of Narrative Form.

This model was applied to all 73 narratives. An example of the model applied to a narrative is provided in the Appendices (see Appendix 2f).

Phase Three: Identify meaning of individual narratives:

Story events and meanings (evaluation components) were identified from each of the narratives (Hill Bailey & Tilley 2002).

Each individual narrative was analysed to identify the meaning of the narrative event for the individual. An example is provided in the appendices (see Appendix 2g).

Phase Four: Identify thematic categories:

Stories with similar meanings were examined within and across the interviews to identify thematic categories (Hill Bailey & Tilley 2002).

This final stage involved the search for recurring meaning across the narratives. In this way the narratives were analysed thematically. This is recognised as a common approach taken to narrative analysis, and frequently is used as a means of uncovering patients' experiences of illness (Overcash 2003, Riessman 2008). The thematic approach differed from the earlier thematic analysis in so far as the participant story was kept intact. In this way the data were not fragmented by coding segments, but instead the narrative was preserved to retain the wealth of detail contained in longer sequences (Riessman 2008). The primary interest was on identifying recurring meanings in 'linked stories' within an interview and across interviews (Hill Bailey & Tilley 2002).

The identification of themes occurred on two levels: intra-interview and inter-interview. The former level required that similarities of meaning were identified within an interview, and the latter required that similarities of meaning occurred across interviews. Using both levels of analysis ensured that data were thoroughly reviewed and compared in a systematic and reproducible manner (Overcash 2003).

Quality Assurance

As I was working alone, there was a risk that the findings might be overly influenced by my own feelings and pre-conceptions (see also Chapter Five, Reflexivity). To manage this risk three quality assurance measures were adopted. The first measure involved the use of data display tables, a methodological tool to analyse and verify findings. Data display tables have been identified as an ancillary strategy in aiding the assessment of the trustworthiness of qualitative findings. They are a methodological tool which enables the researcher to systematically enter qualitative data into matrices (Marsh 1990). The entry of data into a matrix (grid like table with rows and columns) enables the researcher to view large amounts of data simultaneously, and through this, patterns (or the absence of patterns) become evident (Marsh 1990). This methodological tool was used to search for patterns in the data across the entire data set (i.e. all 18 transcripts). Also, this analytical tool enabled me to remain close to the data, something about which I felt concerned, as it may have been lost by use of a computerised analytical package. The tool was used as part of the analysis, to test out my intuitions and hypotheses, to question the data, cross reference the data, and to verify or dispute findings. The data display tables enabled me to search for relationships between and amongst categories of interest, to look for patterns, for gaps, and unforeseen findings (Averill 2002). The data display template is provided in the Appendices (see Appendix 2h) and completed tables are presented in Appendices 3a- 3j.

The other two quality assurance methods were applied to the more in-depth narrative data. These included a search for disconfirming evidence, and the independent reading of narratives by one of my supervisors. Chase (2005) points out that when completing narrative enquiry the researcher has a responsibility to the narrator when interpreting their data. This responsibility requires that the researcher attends to the full diversity of narratives heard, giving credence to both dominant and marginal narratives. Importantly the researcher must attend to narratives which oppose and challenge the researcher's interpretations. To further counter the risk that the findings might just reflect my own interpretations, some of the narratives were submitted to one of my supervisors (JT), who is experienced in narrative analysis. Once read, discussions took place on our respective

interpretation of the narratives, providing a means of checking the plausibility of my own analysis.

Ultimately these three quality assurance measures provided a means of cross checking my findings aimed at enhancing the trustworthiness of the findings (Saks & Allsop 2007).

Chapter Summary

A constructivist ontology, a subjective epistemology, and an interpretive narrative methodology informed the study. The work was influenced by a postmodernist ideology. Creswell (1998) states that researchers' ideological perspectives arise in response to their personal concerns. For me these concerns were focused around hearing the voice of those infrequently heard in the healthcare system. The ideological perspective of the study was therefore focused on hearing the voices and views of older patients and their informal carers.

The sample for the study was drawn purposively from a larger RCT, which was investigating the effectiveness of an interface geriatrician service on an AMU. The method employed was the in-depth interview, which was aimed at eliciting both opinions/views and narratives. It was anticipated that through using in-depth interviews, the voices of older people, and their informal carers, would be heard and potentially influence the care delivered by future healthcare professionals.

Two analytic methods were adopted; thematic and narrative analysis. I have sought to be open and transparent in this chapter by detailing how each analytic method was applied to the data. The final findings represent the fused results of the analysis methods. The analytic methods together captured rich data which might have been lost by utilising one method alone. The value of combining thematic and narrative analysis has been recognised in the literature (McCance et al 2001). The analysis was further supported by the use of data display tables, a methodological tool to verify patterns and identify gaps in the findings. Additional quality assurance methods were also utilised in an effort to enhance the trustworthiness of the findings. These findings are presented in the next chapter.

Chapter Four

Findings

Introduction

This chapter presents the findings from the two main analytical approaches: thematic and narrative analysis. Each approach enabled comparison of the information gleaned from the other, and as such complemented each other. The findings are thus a synthesis of data from both of these approaches. As a postmodern ideology informed this study it is emphasised that the findings are an interpretation, based on the co-construction of the meaning of events and experiences by the participants and myself.

Themes

The analysis revealed five themes, some of which had sub-themes. The main themes were consistent across the two analytic approaches. Some sub-themes were not present in the smaller sub-sample subjected to narrative analysis. The themes, sub-themes and data source are shown in Table 5 over the page.

Reporting of Findings

Each theme is illustrated with quotations from both the thematic analysis (which have been given the identifying label of 'TA'), and narratives from the narrative analysis (given the identifying label of 'NA'). As is usual for narratives, each narrative is given a title, giving the reader a sense of the story to follow. Each narrative contains a 'highlighted evaluation', as per Labov and Waletzky (1967) model (see Chapter 3, Methodology, page 58). The evaluation has been highlighted as this is the most important component of the model (Cortazzi 1993). The other elements of the model are not highlighted in the narratives. This is due to the recognition that readers unfamiliar with the model can find the narratives unreadable when interspersed with all the elements (Riessman 2008).

The selected quotations and narratives cover the breadth of perspectives, rather than focusing on the most vocal or articulate participants or more sensational quotes.

Where quotations or narratives include an interplay between myself (as the interviewer) and the participant or participants the following abbreviations are provided:

Int: Interviewer

Pt: Patient participant

C: Carer participant

Where names are provided in the text they are pseudonyms. One participant (Freda) had expressive dysphasia yet quotes are given verbatim.

The number of participants, and the strength of response provided by each of the participants, for each theme and sub-theme, is provided in the data display tables (see Appendix 3a-3j).

Table 5: Themes and Sub-Themes

Theme title	Source	Sub-theme title	Source
1.Shortfalls in Satisfaction	Thematic & Narrative analysis	a) Perceived lack of treatment	Thematic analysis
		b) Constant disturbance	Thematic & Narrative analysis
		c) Waiting	Thematic & Narrative analysis
		d) Discharge uncertainty	Thematic & Narrative analysis
		e) Inadequate communication	Thematic & Narrative analysis
2. Staff Recognition	Thematic & Narrative analysis	a) Dispersal of blame	Thematic analysis
3. Nebulous Grasp of Geriatrician Service	Thematic & Narrative analysis		
4. On- going Needs	Thematic & Narrative analysis	a) Unresolved health issues	Thematic & Narrative analysis
		b) Unresolved daily living needs	Thematic & Narrative analysis
		c) Impact on informal carer	Thematic & Narrative analysis
		d) Value of independence	Thematic & Narrative analysis
5. Stoicism	Thematic & Narrative analysis	a) Ageing assumptions	Thematic analysis
		b) Modest expectations	Thematic & Narrative analysis
		c) Minimized needs	Thematic analysis
		d) Passive acceptance	Thematic & Narrative analysis

Theme 1: Shortfalls in Satisfaction

Most of the participants interviewed portrayed an overall positive impression of the AMU. However the analysis highlighted that the participants frequently hinted at weaknesses around care delivery, and their language, although often subtle, revealed shortfalls in satisfaction around the care and treatment received on the AMU, and with the discharge process. All but two of the participants expressed weaknesses or flaws when recalling the care and treatment received on the AMU.

There was a pervasive view in this theme that things were satisfactory but could be better.

This was a very large theme and the findings within the theme clustered around five sub-themes: a) Perceived lack of treatment, b) Constant disturbance, c) Waiting, d) Discharge uncertainty and, e) Inadequate communication. These sub-themes related to the first two objectives of the study: One: To explore older patient and informal carer perspectives of the care and treatment received whilst on the AMU, and: Two: To explore older patient and informal carer perspectives of the care and treatment received relating to discharge from the AMU.

The five sub-themes are reported below:

a) Perceived lack of treatment

This sub-theme revolves around the perception that patient participants were not actually treated; rather they were just monitored and observed. The participants spoke about being checked on regularly, and being 'kept an eye on', rather than being actually treated. They spoke about staff regularly monitoring their temperature, blood pressure, oxygen levels, and taking blood samples.

One patient participant, Albert, presented to the emergency department with chest pain, and spoke about just being monitored on the AMU. He said that no treatment had been provided, and stated the following when asked specifically about his treatment:

"Well, nothing really. Just monitoring. Just had observations every hour or so, blood pressure, being diabetic they come and took my erm sugar level every now and again, examined me two or three times, but, never had any medication other than my tablets which I took in with me" (Male patient, age 78, TA).

Albert spoke about the AMU staff keeping an eye on him, but did not perceive this monitoring as part of his treatment. He associated treatment with medication, specifically tablets.

A second patient participant, David, presented to the emergency department with diarrhoea, and like Albert did not perceive he received much in the way of treatment whilst on the AMU. He stated:

“Er, I didn’t get much treatment at all really did I? [Looking to wife]. None at all, no, no, they just more or less kept an eye on me, took my blood pressure and that was regular” (Male patient, age 80, TA).

David, like Albert, appeared to link the concept of treatment with the provision of medication, and did not associate monitoring as part of the treatment. He remarked later in the interview that the staff had sent him home with no new medication.

One of the carer participants, Keith, similarly perceived that the emphasis was upon observation rather than treatment on the AMU. Keith had called out the GP due to concerns about his mother’s health, and she had subsequently been admitted directly onto the AMU. He stated:

“I don’t think its [AMU admission] had a positive or detrimental effect on her. Because all they did, took her in there for obs, and that’s it. They just saw how she was, yer she’s ok, she’s stable, send her home. No extra or different treatments like. That’s it” (Carer, son, TA).

Keith stated that no new diagnosis had been provided, and that his mother had returned home with no change to her condition. He perceived that nothing new had been done for his mother during her short AMU stay.

In summary, the data in this sub-theme centred on the perceived lack of treatment which participants received during their AMU stay.

b) Constant disturbance

This sub-theme revolves around the difficulty patient participants experienced whilst trying to rest or sleep due to the amount of activity continually occurring on the unit, be it staff activity or other disturbed patients. The participants spoke about the constant disturbance created by other patients in adjacent beds or by the staff themselves. For example, participants spoke about being disturbed by patients constantly calling out throughout the day and night, and about the distressed behaviour of other patients in close proximity to them.

Edna provides an example of how participants were disturbed by other patients on the AMU. Edna was admitted to the AMU following a fall. Her most memorable

experience was related to the disturbance created by a patient in the adjacent bed. She recalled how this patient had been shouting out for attention throughout most of the night. This patient had not settled with the intervention of the nursing staff, whom she reported were becoming annoyed, and so Edna eventually felt it necessary to intervene herself. The following quotation relates to this memorable experience:

Int: "Have you got anything that stands out particularly as memorable?"

Pt: "Only the woman screaming all the time, yelling out".

Int: "So how long was that going on for?"

Pt: "Nearly all night till I told her to shut up [laughs]. I says to her for goodness sake woman shut up. I said there's no need for all that noise" (Female patient, age 89, TA).

She later went on to say:

"I mean she was keeping everybody awake. There was a woman in the next bed to me she says "oh I'm glad you told her off"; I said well "why didn't somebody else do it before I did"? [Both participant and interviewer laugh] (Female patient, age 89, TA).

Another patient participant, Beryl, who was admitted to the AMU with chest pains, similarly spoke about being persistently disturbed by a patient in an adjacent bed. This young patient was constantly shouting and crying out, and demanding attention by banging on the nurses' station and physically throwing herself onto the floor. Beryl explained that this patient had been admitted following an over-dose and was threatening the staff that she would take her own life. One of her narratives is provided below:

I've never felt like that in hospital

*But it was just because of this girl, that was the problem, you know, she just didn't **shut up** [emphasised words], she just kept on an on and on.*

.... I mean she started as soon as she got on the ward.

And er, she never shut up

*until er about 3 o'clock in the morning
and she just went quiet
and that's when all the trouble started,
when er when the nurse come and had a look
and er started shouting for scissors,
so er, I don't know.
But er, no I've never had that erm problem,
never felt like that when I've been in hospital before
(Evaluation)
In **fact** [emphasised word], it was half in me mind to say
can you ring me a taxi [laughs],
I want to go home.
(Female patient, age 80, NA).*

This was a repeated narrative for Beryl and its repetition highlighted the impact that the behaviour of this one patient had upon her, right from admission through to the early hours of the morning. Both Beryl, and her daughter, raised concern about the appropriateness of patients with 'psychiatric problems' being nursed alongside patients who have potentially just experienced a 'heart attack'. They did not limit this concern to themselves, but spoke about another patient in the bay who had similarly experienced a suspected heart attack.

The data in this sub-theme was not only limited to the disturbance of other patients, but also by the disturbance created by the amount of continual staff activity occurring around them. What was evident from participant comments was that the AMU was constantly busy both day and night, with staff admitting patients, assessing and treating patients, and discharging patients. The participants were disturbed by staff constantly walking up and down the Unit, by staff completing other patients' observations and tests, by staff sifting through patient notes (these were in trolleys at the end of each bay), by the telephone constantly ringing, by staff telephone conversations (the telephone, like the patient notes, was positioned at the end of each bay), and by staff moving beds around. These disturbances occurred both day and night.

Grace spoke about the constant disturbance occurring on the AMU over the night. This participant was admitted to the AMU after she had been coughing up blood over a long period. She arrived on the AMU in the early hours of the morning, but recalled that she could not sleep for the duration of the night. This was attributed to the constant disturbance created by staff activity. She stated:

“...and I didn’t sleep one little bit, because there was beepers going over peoples beds like you know... and erm, there was action all night, up and down, up and down” (Female patient, age 79, TA).

Grace’s memory of her night on the Unit included staff walking up and down the corridor, trolleys being fetched and moved around, patients being admitted and leaving the Unit, and staff completing observations. She felt that even if staff had pulled the curtain around her bed to provide some privacy she still could not have slept.

In summary, the data in this sub-theme centred on the constant disturbance experienced by the patient participants during their AMU stay, either as a result of disturbed patients around them, or due to constant staff activity.

c) Waiting

This sub-theme revolves around the amount of waiting that participants experienced. The participants specifically spoke about the following in relation to waiting: the need to wait for a bed on the AMU, for tests or investigations, for information, to see a doctor, permission to go home, discharge letters, medication, ambulance transport, and just for something to happen.

Patient participants spoke about how long it felt while sitting or lying whilst waiting for staff. The feeling that participants were waiting on staff is summed up by Annie:

Int: “What stands out, what memories have you got of being on that ward?”

Pt: “Ohh well not a lot really, because so you say, you’ll just in bed waiting for what going, well what they are coming to tell you what’s going to happen, so I say all it was is just laying in the bed...” (Female patient, age 78, TA).

Annie was taken to the emergency department following an unexplained seizure. She spoke about waiting for a long period in the emergency department for an AMU bed, and then once on the Unit, lying in bed waiting for staff to do something or make a decision, and finally waiting for medication after the discharge decision had been made. The theme of waiting thus extended throughout her entire stay.

Another patient participant, Charles, recalled how he had to wait for four hours for a scan which never materialised:

I waited four hours for nothing

*Well the doctors, I could see the doctors,
there were four of them,
cause this nurse, I said "I'm waiting for the doctor in actual
fact",
she said "well there's four of them look,
when they get to you just ask one of those".
So, and they were all er foreign, you know,
so obviously it's hard to listen to them,
and I said "when am I going down for a scan?"
"Oh yes it's all been arranged today",
then I'm still there another four hours.
Never materialised, no (Evaluation).
(Male patient, age 74, NA).*

Charles was admitted directly to the AMU via his GP with a suspected deep vein thrombosis. He spoke about how he spent the entire day on the Unit waiting for a scan, to determine if a clot was the cause of his swollen leg. However this scan was not completed, and he was subsequently told at six o'clock in the evening that he could return home. Both Charles, and his wife, spoke about the "wasted day" spent on the Unit. Despite waiting for an entire day, Charles had to return to the hospital at a later date, so that the ultrasound scan could be completed.

The data in this sub-theme also extended to the discharge process. Waiting for discharge resulted in feelings ranging from boredom, to anxiety through to discomfort. Several of the patient participants spoke of waiting during this stage,

either for permission by the doctor to go home, medication, the discharge letter or for hospital transport home. Freda stated:

“... and she [nurse] says “ohh Freda” she said “you might come to the home, you might go home today”. So I says “ohh that would be nice that would be lovely”... So she says, “oh, but wait a bit” she says, “I haven’t said anything”. She says “because you got to ask the doctor first”, and then of course after that the doctor says “I think you’ll be going home, but she says I don’t know what time”, well that was 10 o’clock, well I never got to get going in to see till 4 o’clock” (Female patient, age 81. TA)

Freda was admitted directly to the AMU via her GP after a sustained period of vomiting. Although she was expressively dysphasic following an earlier stroke, she was able to articulate that she had to wait six hours before going home.

In summary, the data in this sub-theme centred on the long periods of waiting that participants experienced during their AMU stay, from waiting for a bed on the Unit through to waiting for transportation home.

d) Discharge uncertainty

This sub-theme revolves around participant uncertainty about how long they would remain on the Unit. The findings highlighted how the participants felt uncertain when they would be discharged from the AMU. Such uncertainty can prevent patients from relaxing as they feel discharge is likely to be imminent. Grace provided several examples of how uncertainty about the time of discharge impacted on her experience of the AMU:

Firstly she remained in her clothes throughout the night:

“Rachel [neighbour] had packed me a nightie and packets of baby wipes and couple of pairs of knickers and things like that, erm and er she [nurse] said “would you like to put on a nightie, a night dress on Grace?” I said “oh I’m in my clothes now, oh I’m going home in the morning” (Female patient, age 79, TA).

The following day she declined ordering food from the tea time menu:

“... and then they came round “what would you like for your tea Grace?” And I said “well I don’t think I will be here”. .. So

anyway, erm, er this er the nurse, I said to this erm, one of the nurses, I said “do you think I’m going home? I haven’t seen a doctor” (Female patient, age 79, TA).

She then went on to outline how she had declined the offer of a book to read to alleviate boredom:

“And then I had a lady in, presumably it was her husband, er come round with the books, wanting, “do you want to”, I said “there’s no good me borrowing a book” I says ... “well I don’t think I’ll have a book because I’m hoping to go home”. It’s a good job I didn’t get one weren’t it because I went home” [laughs]. (Female patient, age 79, TA).

Grace, like some of the other patient participants, could not truly relax as she was uncertain when the staff would discharge her. Although the patients could not relax, the carer participants spoke more about frustration when trying to establish the time of discharge. Discharge was the most burning issue raised by the carer participants (most had little involvement in the short hospital stay but became involved when the patient was being discharged back home). One of the carers, Jane, spoke about the problematic experience of collecting relatives from the hospital:

Discharge was the biggest hassle ever

*Well from the **previous time** [emphasised words] you were in we knew what a hassle it was trying [laughs] to discharge you,
erm and so the night before
when you were took up on the ward,
I said look when you discharge this time
I’ll bring your own wheelchair,
park the car
and take you to the car in your own wheelchair.
Erm but of course I’d arrived just thinking,
you know you would be there for a day or two
so I hadn’t got your wheelchair with me.*

*Erm and it was a hassle again wasn't it [laughs]
discharging you... (Evaluation). (Carer, daughter, NA).*

Jane spoke of an assumption by staff that the informal carer will take the patient immediately home. She stated that with forewarning carers can make preparations to ease the discharge process. Otherwise the carer is left trying to transport an immobile relative to the car park, some distance from the AMU. Jane perceived that this whole process was a “hassle”, a repeated phrase which occurred in the evaluation components of several of her narratives.

The carer participants spoke about either arriving on the Unit to visit their relative, only to be told to take them home, or conversely about spending their time telephoning the Unit for a time to collect their relative. Clare, one of the daughters, provides an example below. This narrative has been selected because it reveals how the discharge process impacted on both the patient and carer. The narrative is set against a backdrop of an intense day, in which Clare had been phoning the AMU on a half hourly basis to establish when her mother could be collected. It transpired later in the interview that the staff did not communicate to the patient that her daughter had phoned.

For crying out loud

*C: but on the following day after I'd,
when I went to pick Mum up,
when Mum said to me [laughs],
I walked through the door
and Mum said to me
“I'd thought you had an accident”
and I felt like,
for crying out loud Mum (Evaluation),
you know, when I think how...*

Pt: Felt like hitting me I bet.

*C: Pretty much yer [laughs],
I thought I've been ringing this place all day...*

Pt: And I'd been sitting there thinking

what's happened to her, what's happened to her?
C: *and trying to come and pick,*
but got here as soon as I possibly could
and this is the greeting that I get [laughs].
Erm you know, and with all the day before
as well, and then of cause Mum's experience on top,
erm which I wasn't aware of obviously
until I picked her up,
erm I think,
if you did the interview then,
the response you would get would be very different
(Evaluation).

(Female patient, age 80 & carer, daughter, NA).

Clare repeated the narrative of trying to collect her mother on a couple of occasions, and its repetition reveals the full extent of Clare's frustration with establishing when she could take her mother home.

In summary, the data in this sub-theme centred on the uncertainty experienced in respect of discharge. The sub-theme was evident amongst both the patient and carer participants, affecting both in different ways. The former were unable to relax whilst on the Unit, and the latter either had to drop everything to fit in with the AMU discharge, or conversely spent their time telephoning the Unit and hanging around until the AMU staff made the discharge decision.

e) Inadequate communication

This final sub-theme revolves around the inadequate communication provided by the AMU staff. Participants spoke about a lack of explanation or information provided during their stay. This lack of information related to assessments and treatment, about staff contact made with relatives, and generally about what was happening. Some participants spoke of insufficient reassurance or apology if events were disturbing, giving the impression of an uncaring staff attitude. An example is again provided by Charles, who as outlined earlier, had waited over four hours for a non-existent scan. He said:

Pt: "They [staff] never come to you and say oh I'm sorry you've sat there a long time Charles".

C: "He'd been there all day".

Pt: "Never said anything like..."

Int: "No one was telling you anything?"

C: "No no".

Pt: "I was asking all the time. When am I going down? [For the scan]. And its, all it was, was er oh yes your definitely going, not we're sorry, you know anything like that" (Male patient, age 74 & carer, wife, TA).

Even participants experiencing distressing situations, such as Beryl, who as mentioned earlier, had been constantly disturbed by a young psychiatric patient in an adjacent bed, spoke about receiving only a minimal amount of reassurance from the nursing staff:

"... one of the male doctors came and he was taking my erm blood pressure and err I think he saw it was upsetting me a bit, and he must have, I think he must have told the, the sister, she just came and said "I'm sorry about all this", but she said "she is well known", but that was all, all I got" (Female patient, age 80, TA).

Beryl goes on to highlight how upset and vulnerable she felt by the whole situation, stating that she felt "nervous", and found the whole experience "scary", and yet she speaks of little in the way of staff reassurance.

The data in this sub-theme also included situations where participants spoke about discussions taking place between doctors, rather than directly with themselves. An example is provided by Albert, who as outlined earlier, was admitted with chest pains. Albert said:

"...they [doctors] came in Saturday morning, the normal rounds, this young doctor, he was chatting, how they chat in their little groups, and they were chatting away, and then they walked away and then the nurse come and said oh the doctor said you can go home now" (Male patient, age 78, TA).

Albert queried the discharge decision with the nurse, as he had been informed by a doctor the previous day that he would need to stay on the Unit over the weekend whilst he was monitored. He went onto say:

“I said I thought I was going to [stay], she [nurse] says “the doctor says you can go home” [demonstrates that nurse just shrugs her shoulders]. But so you can go home” (Male patient, age 78, TA).

No discussion was pursued. The discharge decision was thus made without consultation with the participant.

Leonard, who was admitted to the AMU with abdominal pain, also raised the issue of doctors talking amongst themselves:

That upset me

*And then the doctor come round with his **team** [emphasised word],*

and er that upset me [quieter tone of voice] (Evaluation),

because he was talking to the man opposite, in bed,

and I heard him say er,

there was three of them with him,

And I heard him say

“right you must remember now that he’s getting old and feeble,

so we’ll go and have a look at him”.

*And I looked round and then they come to **me** [emphasised word] [laughs]*

... and er [laughs], I thought,

*Oh, that’s **surprising** [emphasised word] [laughs].*

I looked at it as a joke,

I mean I didn’t take offence at it at all (Evaluation).

(Male patient, age 87, NA).

Leonard gave two similar narratives about doctors talking amongst themselves rather than including him in the consultation. He stated that the doctors did not want him to hear their discussions.

In summary, the data in this sub-theme centred on the inadequate communication of the AMU staff. The participants provided examples of inadequate explanation and reassurance, and examples of staff communicating amongst themselves rather than directly with the participants.

Theme 1 Summary

The findings of the theme of 'Shortfalls in Satisfaction' highlighted five key areas of dissatisfaction as experienced by patients and carers, and these areas were represented by the five sub-themes. These sub-themes revolved around: a perceived lack of treatment, constant disturbance on the Unit, waiting around for staff, discharge uncertainty, and inadequate communication.

Theme 2: Staff Recognition

The 'Staff Recognition' theme relates to the first aim of the study: To explore older patient and informal carer perspectives of the care and treatment received whilst on the AMU. Despite recalling weaknesses around their care delivery, the participants voiced positive recognition of the staff on the AMU. The analysis revealed that the same participants that voiced dissatisfaction in the earlier theme also praised the staff in this theme. All but two of the patient participants (Beryl and Charles) spoke favourably about the staff on the AMU.

The data in this theme centred on participant praise of the staff on the AMU. The participants spoke about the staff being good, kind and caring. The participants felt they had been looked after on the AMU, felt their basic needs had been met, and were happy with the care they received on the AMU. The analysis revealed that the participants wished to express the positive attributes of the staff, saying that all the staff, from those clearing up the wards to the doctors were lovely, helpful, pleasant, and caring. Participants outlined how attentive the staff were, checking on them regularly and ensuring they had everything they needed.

The following three patient participants successfully illuminate the theme. Doris was admitted to the AMU with extreme lethargy. She repeatedly praised the staff

on the AMU, stating that they treated her as well as royalty. She stated that the staff were both lovely and attentive:

“Well they couldn’t do enough for you, they was, they were little angels, they was really” (Female patient, age 81, TA).

Norma, like Doris, repeatedly praised the staff on the AMU. This lady was admitted with chest pains. She stated that the staff on the AMU were very pleasant, very kind, very efficient, helpful, highly attentive, and caring. She stated that the staff made her feel comfortable and at ease:

“I don’t think they could have done any more, been any more pleasant than what they were. Everyone was so pleasant, the nurses and the staff” (Female patient, age 80, TA).

Leonard similarly spoke about the positive attributes of the AMU staff. He talked about the staff checking on him regularly and ensuring he had everything needed:

What more do you want?

*As I say there was this **small fellah** [emphasised words],
and er he came round every hour,
near enough to check your blood pressure and that,
and as I said,
the moment I stood up,
he knew I was a bit shaky,
and he was there straight away;
“Where are you going,
can I help you?
Hang on to me”.
So I mean, what more do you want?
I don’t know whether I was one of the lucky ones or not,
but er no complaints in that ward whatsoever.
If they treat **everybody** [emphasized word] that goes in
the same as they did **me** [emphasised word],
that’s it, very good (Evaluation).*

(Male patient, age 87, NA).

Leonard provided a further scattering of evaluations across a second longer stretch of narrative, where he periodically stepped back to judge the AMU staff, whom he appraised as “good”, “kind” and “brilliant”. He voiced that their level of attentiveness made him feel safe. These three patient participants, like many of the other participants, voiced that the staff on the AMU could not have done any more for them.

The data in this theme also included comments whereby participants, like Leonard above, singled out individual members of staff for praise. In doing so the attributes of care valued by participants were revealed. An example is provided below by an interwoven narrative given by Kath, and her daughter, Jane. The paramedics were called out when Kath was experiencing severe shortness of breath. Kath was subsequently admitted to the emergency department, where she was prescribed diuretics, and consequently frequently needed a bed pan. Once on the AMU both mother and daughter singled out an individual nurse for praise:

One nurse was excellent

- C: *Well when you,
no when you've was first admitted [onto AMU]
the nurse was very good,
she went,
when I said that you'd hadn't had anything to eat
she went and made you some hot milk...*
- Pt : *Yer.*
- C : *then you was still in the hospital gown weren't you?*
- Pt : *Yer.*
- C : *Erm, and your sheets were wet...*
- Pt : *Yes.*
- C : *and I think that was from the bedpan...*
- Pt : *Yer because and they spilt it
I think when they took it away.*
- C : *And you needed the bedpan again didn't you?*

Pt : *Yes. And she did change the bed.*

C : *Yes she, she was excellent,*
she didn't go and see to anybody else,
she concentrated on you,
you had the bedpan,
then she put you in the chair
and changed your sheets
and made you comfortable in bed didn't she?
(Evaluation):

(Female patient, age 88, & carer, daughter, NA).

This narrative, like others, highlighted the attributes of care valued by participants. They particularly valued staff that were attentive and checked on them regularly. This included noticing and removing wet clothing, assisting with toileting, and providing basic toiletries and basic refreshments.

In summary, the data in this theme centred on the positive recognition by both patient and carer participants of the staff on the AMU.

a) Dispersal of blame

The theme of 'Staff Recognition' appears on the surface to contradict the earlier theme of 'Shortfalls in Satisfaction'. The data in this sub-theme however revolved around the participant desire to dispel any blame away from the staff for the shortfalls they experienced in respect of their care delivery. There was a clear pattern whereby participants both praised the staff but also offered excuses for any shortfalls in their care delivery. These shortfalls were considered outside the remit of the AMU staff. Participants instead blamed a host of external factors for any dissatisfaction experienced, and this included governmental cut backs, and a shortage of beds and staff.

David and Albert spoke about the staff being very busy and about shortfalls being attributed to factors outside the remit of the staff. Their quotations have been selected as they reflect the data of other participants in this sub-theme.

David recognised that the AMU staff were busy looking after other sick patients. He voiced that the staff were overworked, there was a shortage of beds, and insufficient finances for the service:

“I mean they’re busy all the time, you can’t expect them to ... you know if you shout them you can’t expect miracles, they’re looking after people” (Male patient, age 80, TA).

Similarly, Albert spoke about the staff “flying about”, and the number of sick patients in need of care. Albert compared the Unit to Clapham Junction, with staff “dashing all over the place”. He stated that he believed that the staff did the best they could in difficult circumstances:

*“You know there, somebody goes and they’re not replacing them which, so you know they’re rushing about a little bit, and people do get to the stage where probably they’re not getting erm things done **quite** [emphasised word] as quickly as what they were getting before, I never had a problem with them in there”* (Male patient, age 78, TA).

Like other participants, Albert was keen to point out that the staff were not to blame for weaknesses in his care delivery. He stated:

“... I mean I don’t blame anybody, you know the nurses rushing about, back and forth” (Male patient, age 78, TA).

The interpretation of the ‘Dispersal of blame’ sub-theme was that staff were perceived to be very busy, and that these staff worked hard and did a good job considering the pressure they were under. As succinctly stated by Ida, who was admitted to the AMU following an accidental fall:

“I mean when you think of the people they have in and out, in and out, all the time, I think they do a remarkable job, don’t you?” (Female patient, age 88. TA).

In summary, the data in this sub-theme centred on the participant attempts to disperse blame away from the AMU staff for the shortfalls that they experienced during their AMU stay.

Theme 2 Summary

The findings in this theme highlighted how participants praised the staff on the AMU despite the shortfalls that they experienced in respect of their care delivery. Where such shortfalls existed participants dispersed the blame elsewhere. Hence shortfalls in care delivery were not attributed directly to the staff on the AMU, but rather to external factors.

Theme 3: Nebulous Grasp of Geriatrician Service

This theme relates to the third aim of the study: To explore older patient and informal carer perspectives of the interface geriatrician service. This theme was underpinned by a strong expression regarding the positive attributes of the geriatricians in the study. The participants spoke about the geriatricians in a favourable manner. They perceived the geriatricians as being pleasant, and appreciated the extra attention which was provided by the geriatricians. No participants provided unfavourable or negative comments about the geriatricians.

The majority of the patient participants could recall seeing the geriatrician and were keen to point out how pleasant they found him/her. They talked about the geriatrician spending time with them, and asking them questions. They spoke favourably about the geriatrician saying that he/she was very good, pleasant, or indeed charming. Participants implied by their language that the geriatrician possessed a pleasant bedside manner. The overall feeling generated by the geriatrician involvement was positive. Participants frequently described the geriatrician as “nice” and “good”. Edna recalled that the geriatrician was pleasant and appreciated him visiting her at home:

Int: “And tell me what his [geriatrician] done for you?”

Pt: “I don’t know what his done really. Just to talk to me that’s all, yer he was quite nice really, he come, and the nurse said it’s very rare that he ever visits patients outside” (Female patient, age 89, TA).

A further probe was used to encourage greater expansion:

Int: “What did he do when he came to see you?”

Pt: "Oh he only, he sat there [indicating the sofa] just talked to me that's all. Asked me what, how I was and was I going on alright and that kind of thing. You know. He was quite nice actually. Nice person" (Female patient, age 89, TA).

Edna, like several of the participants, voiced that the geriatrician was pleasant, but was unable to verbalise what the geriatrician had actually done for her. Similarly, Grace, a participant with a long standing fear of hospitals, described the geriatrician as a "charmer". She outlined how the geriatrician tested both her memory and her mobility. She went on to say:

"...oh he's [geriatrician] his extremely nice person, and erm, but er, as I say he really and truly, you could feel at ease with him. You know you wouldn't have thought he was a doctor, and he's got a pleasant side to him for the patients hasn't he? And er so when he came to the house like, erm, he says "is there anything I could do for you?" I said well, erm "you could have wiped the pots up, but I've done them" [laughs]. And he, as I say his very very nice, wouldn't be frightened to meet him again" (Female patient, age 79, TA).

Once again, a further probe was used to encourage greater expansion:

Int: "So did he do anything for you, did he need to do anything for you?"

Pt: "Erm no he didn't really because I'm quite capable of doing a lot for myself, erm, I have difficulty erm getting dressed in the morning, erm, I can take my knickers off but I can't put them on, er in [the community hospital] I could, erm because the bed was higher, erm, but I've aged a couple of years since I was in there, but no that's the only thing..." (Female patient, age 79, TA).

Like many of the participants Grace was vague about the actual geriatrician intervention, but she did articulate some unmet needs, such as difficulty getting dressed and having low furniture which limited her independence. These needs however do not appear to have been addressed by the geriatrician intervention.

There was an overall lack of awareness amongst the participants on what the geriatrician had actually done for them. Participants, like Edna and Grace, spoke vaguely about the geriatrician just talking to them or examining them, and some

participants stated the geriatrician had done nothing. Only two participants, David and Norma, were able to clearly articulate the geriatrician intervention.

Theme 3 Summary

The data in this theme centred on the participant desire to express the positive attributes of the geriatricians that were working on the RCT study. The participants articulated that the geriatricians possessed a pleasant bedside manner. They appreciated the extra attention given by the geriatricians on the study, however, the majority of the participants were unable to state what the geriatrician had actually done for them.

Theme 4: On-going Needs

The findings in this theme relate to the fourth aim of the study: to explore how a short stay on an AMU impacts on older patients and informal carers perceptions of their everyday activities (ADLs) once back home. The analysis highlighted that the patient participants had a whole host of on-going needs which were not addressed as part of the AMU admission or by the RCT geriatrician intervention. All but two of the patient participants spoke about at least one on-going need or issue following their discharge from the AMU. Over half of the participants raised concerns related to on-going concerns with their health, and all but two of the participants raised issues in relation to their ADLs. The strength of concern varied, but some of the participants repeatedly raised concerns during the course of the interview.

This was a large theme which was united by a central tenet that participants returned home from the AMU with on-going needs. The data in this theme were clustered around four sub-themes: a) Unresolved health issues, b) Unresolved daily living needs, c) Impact on informal carer and, d) Value of independence.

The four sub-themes are reported below.

a) Unresolved health issues

The data in this sub-theme revolves around the patient participant perception of on-going problems with their health despite their recent AMU admission and assessment by the RCT geriatrician. Several of the participants expressed concerns about on-going symptoms which had been directly attributed to the cause of their AMU admission. Norman, admitted onto the AMU with back pain, explained

how this pain remained throughout his admission and continued post discharge.

He stated:

“Well I was more or less stationary, I mean I couldn’t move, with me back, I know I keep on about me back but I couldn’t move... I was, was, I couldn’t even go to the toilet” (Male patient, age 76, TA).

Norman raised concern about his unresolved symptoms on ten separate occasions during the course of his interview. He had been admitted into hospital for the same symptoms only months before, and spoke about his concern that he had been discharged prematurely from the AMU. Norman spoke about experiencing severe back pain whilst on the Unit, about the lack of information given by staff following investigations, and about the difficulty he experienced in getting dressed to leave the Unit due to the extent of his pain. Norman left the Unit with the very symptoms that took him into hospital, and because his symptoms persisted he called out both his general practitioner and the out of hour’s emergency service. He spoke about the symptoms preventing him from mobilising around his flat or completing his everyday activities. When asked how he was managing at home since discharge he stated:

“Well, not my normal self, I’ll not keep on about it, not my normal self love, because I can’t seem to get me normal things done, part from carers coming in and helping me extra you know” (Male patient, age 76, TA).

Like many of the other patient participants, Norman voiced that there had been no change to his condition as a result of either the AMU stay or the geriatrician intervention.

Annie, like Norman, repeatedly raised concern about the very symptoms that attributed to her admission. Annie was experiencing seizures, which a doctor on a previous admission had suggested might be attributed to hair dye:

Why is it happening?

One [seizure] were January, January something, 18th I think, something like that anyway, and then it were about I say about four weeks, three or four

*weeks after,
and er that was the early hours of the morning that one
happened
same sleep again,
but when it, I, erm, I coloured my hair again it er didn't bother
me,
nothing happened, **nothing's happened since** [emphasised
words].
Why's it happening there you see? (Evaluation).
(Female patient, age 78, NA).*

In this narrative Annie is struggling to understand the cause of her seizures. Annie recognised that if the cause could be identified, then she might be able to prevent the seizures recurring. However the link to the hair dye appears ambiguous and hence uncertainty remained about the cause of her symptoms, and this was despite being seen by both the staff on the AMU and by the RCT geriatrician.

The data in this sub-theme was not only confined to the symptoms which attributed to the AMU admission, as participants also spoke about other on-going problematic health symptoms. Norma, who was admitted to the AMU with chest pains stated:

*"I keep getting trouble at the minute, I keep getting this
phlegm in my throat all the time. And its erm, it's always when
I'm talking [participant goes into the kitchen for a glass of
water]. It's because of my cough because they put me on
Ramipril, a couple of months ago, and ever since then I
developed a cough" (Female patient, age 80, TA).*

Norma was clearly being troubled by her cough, and needed to break from the interview to retrieve a glass of water to calm her symptoms. Although not the cause of her admission, Norma's cough was long standing and problematic.

In summary, the data in this sub-theme centred on the patient participants' on-going concerns with their health, relating both to the acute presenting complaint, and to other underlying health conditions.

b) Unresolved daily living needs

The findings in this sub-theme revolve around the difficulty patient participants were experiencing when completing their activities of daily living (ADLs). One reason for this was the presence of underlying health needs. The analysis revealed that all the patient participants with unresolved health needs also spoke of difficulty completing their ADLs. This suggests that the patient participants' health issues impacted upon their functional ability.

The participants spoke of difficulty completing ADLs across the domains of personal care (washing and dressing, shaving, bathing/showering), domestic activities (shopping, laundry, household cleaning, meal preparation and cleaning the dishes), and leisure/social activities (going out of the home for walks, to attend social groups, to visit family/friends or to engage in previously enjoyed leisure activities such as dancing, going out for a drink, or simply to just get out into their garden).

Quotations from Jean and David have been selected as both participants were experiencing fatigue and shortness of breath, and their comments highlighted how their health was impacting on their ADLs.

Jean was admitted to the AMU with heart concerns. She spoke about her lack of energy to climb the stairs to access her bedroom and toilet/bathroom, to go out shopping, to go into her garden, or to engage in previously enjoyed leisure activities, such as walking or ballroom dancing. An interwoven narrative on the subject of her heart complaint is provided below:

Int: "And is your heart stopping you doing anything else at all on a day to day basis?"

Pt: "Erm, only in as much, I can only do so much and I've got to sit down. And have a rest. Er no I mustn't do any heavy lifting at all because of my pacemaker, erm I think I try my hardest at everything don't I?"

C: "You try to do things, I just think that you find things a lot more tiring than you used to and you used to like to go out for a walk and you get tired if we go out for a walk. And you know it's just, everything is a lot more effort than it used to be"
(Female patient, age 83 & carer, daughter, TA).

Likewise, David spoke about difficulty completing his ADLs. He spoke about experiencing both a lack of energy and shortness of breath. These symptoms were hindering his ability to take part in his ADLs, from engaging in basic activities such as toileting and personal care, to completing activities in his greenhouse and garden. In respect of the latter he said:

“I think we’ll get by, for a bit anyway. But er I say it knocks me out, I love pottering you see, I like to be outside doing. I’m a bodger, don’t get me wrong, I’m not a perfectionist... I like doing what I do, but it’s slowed me down” (Male patient, age 80, TA).

Despite the difficulties that the participants identified completing their ADLs, it appeared that only a few (Ida, Freda, Norman and Jean) were referred by the AMU staff for an occupational therapy assessment, and none were referred for rehabilitation. Indeed one carer, Jane, whose mother had not been referred to occupational therapy, made the referral herself. Her mother was subsequently provided with a whole array of equipment to assist her ADLs. Furthermore, it appeared that none of the participants were referred for either occupational therapy or to rehabilitation services, such as intermediate care, by the geriatricians.

In summary, the data in this sub-theme centred on the difficulty that patient participants were experiencing when completing a range of ADLs. This difficulty resulted in the patient participants being reliant on others, particularly their informal carers, to complete their ADLs.

c) Impact on informal carer

This sub-theme revolves around the patient participant need for assistance with their ADLs, and this assistance was predominately provided by their informal carers. These consisted of the patient participant spouses, their grown up children and grandchildren, and in one case a neighbour. Some of the patient participants voiced a reluctance to accept help outside of the family, and indeed only a few participants had home care assistance. Instead family members frequently helped the patient participant with their ADLs, and shared the activities between them.

Once again Jean and David provide examples of how difficulty completing ADLs ultimately had an impact on their informal carers. Jean’s daughters were visiting

more frequently to help with the ADLs. They were encouraging Jean to get up in the morning, changing her bed linen, ensuring that she was eating, helping her to bed, and completing the shopping. Jean summed up all the support offered by her daughters:

“it’s erm, it’s lovely, and for weeks I never slept in the house by myself, one of the daughters used the spare bedroom. Yes, just to see me in bed, get me up in the morning and be company. Yes they’ve been very good. Cause they’ve all got their own homes, and their own work” (Female patient, age 83, TA).

Jean recognised that her daughters have their own home lives and employment. Indeed her daughter, Diane, later spoke about the demands being placed upon them:

“Its getting quite tiring for us. We’ve got to be honest, erm you know we would rather be coming and taking mum out somewhere, whereas it can get tiring when you get here and realise that she needs some shopping doing or you know the bed needs changing, that sort of thing” (Carer, daughter, TA).

David was supported by his elderly wife with his ADLs. This included helping him to complete his personal care and physically assisting him to climb into and out of the bath. On top of her usual domestic activities David’s wife was also taking on the roles that David used to complete such as washing the dishes, cleaning and preparing the vegetables, and managing the garden. David recognised the demands being placed upon his wife:

“...but its hard work for my good lady there. It makes it hard work for her, it wears her out a bit, but it is, it is hard work. But she’s struggling, she’s getting by aren’t you” (Male patient, age 80, TA).

Another elderly carer participant (Betty) highlighted the extent that she was helping her husband with his ADLs. Betty assisted her husband with his personal care, changed his colostomy bag, and frequently washed the bed linen when this bag leaked or burst. She spoke about her husband’s needs being similar to those of a baby, and the amount of bed linen that needed constantly changing and washing.

On top of all of this Betty was also giving her husband daily injections. The patient participant did receive home care assistance twice daily, but his wife was still assisting him with most of his ADLs, on top of completing all the domestic activities such as household cleaning, meal preparation and shopping. Even the latter was problematic, as she had to assist her husband to transfer into/out of the car and into a wheelchair, which she then pushed around the supermarket. One of her narratives is provided below. This narrative has been selected because it highlights the extent of the demands that had been bestowed on this carer by her husband's ill health:

I can pop out and leave him now

*... but I've got to that stage now Janet where yesterday I said
to Charles
I'm just going to pop down to Morrison's
so he was laid out on the bed,
his table was here, his bottle was here, a drink was here.
I says "I'm only popping out for about half an hour",
but I,
for about the first five, six weeks I never did that,
I used to get somebody to come in (Evaluation),
but I know now that I can just pop off,
just down to Morrison's and straight back you know.
(Carer, wife, NA).*

The point of this narrative is that Betty feels that she can now go out and leave her husband safely at home. However this is only a recent development, and even now she feels she can only leave her husband for short periods of time. Betty acknowledged that caring for her husband was a "full time job".

In summary, the data in this sub-theme centred on the need for support with ADLs from informal carers. The few participants not receiving assistance from informal carers were either largely independent with their ADLs (Barry and Norma), or were supported by formal services (Malcolm and Norman). The data in this sub-theme suggests that the majority of participants were supported with their ADLs by

informal carers. It is interesting to note therefore that despite this high level of support, less than half of the patient participants identified an informal carer at the time of recruitment.

d) Value of independence

The findings in this sub-theme revolve around the participant's desire to complete their own ADLs. Although the patient participants frequently delegated their ADLs to their informal carers, the patient participants did speak about wishing to complete activities themselves, rather than others completing the activities for them. The patient participants perceived that completing ADLs provided a role and purpose in life, met their values, took their minds off anxieties, made them feel better, and provided a range of emotional responses such as enjoyment and pleasure.

Albert spoke about keeping himself busy and occupied by helping out in the local community, such as sitting on stalls at the village fete or holding positions on various local committees. He stated:

Pt: "I'm chair of the local British Legion. And I'm chairman of the residents association down the road. I do erm one night a week, only two hours, volunteering at the police station. Erm yeah, I'm into all sorts. I'm on the legion executive committee in [city], which meets three times a year".

Int: "It sounds like a busy man then between all of that".

Pt: "Well I feel that the busier you are the less time you have got to worry about other things" (Male patient, age 78, TA).

Albert stated that he liked to keep his mind occupied by engaging in a whole range of activities, both voluntary (as outlined above) and leisure (such as attending football matches with his son).

Similarly, Barry, who was admitted to the AMU with chest pains, spoke about filling his time with activities to help others. He voiced that helping others kept him happy and provided him with something meaningful to do:

"Oh yeah, I've got friends in here [retirement complex], I've got, I go and look after a poor old lady... she's blind, she's got arthritis, she's got same as me, hernia, she er got brittle bones, God knows what's she's got. Well I go and sit with her

and that. It's something for me to do" (Male patient, age 77, TA).

Barry stated that he wished to complete activities for himself and did not like "people running after" him. Consequently he turned down the offer of home care assistance, which his niece requested, and reported that he did all his ADLs himself, with the exception of household cleaning. He summarized his independent attitude by stating that he would keep completing his own ADLs until he "dropped dead".

Annie sums up the overall desire amongst the participants to complete activities for themselves in this narrative:

I can do it myself

*And so I say I am going that little bit further on me own...
And me son's off work Mondays, cause he works weekends,
Monday and Tuesday,
and it were yesterday that he came up,
and er, and he says "what are you going to do mum?"
So I says "I might go down to hairdressers and try and get me
hair cut",
well the hairdressers is on [name of road] where he gets the
bus,
"I'll go with you [laughs], I'll go with you"...
And he come down and put me on the bus
yeah he come down.
"I'll take you to the bus stop",
"Pete I can do it meself" [emphasised words] (Evaluation).
"I'll take you to the bus stop".
(Female patient, age 78, NA).*

The point of this narrative is that Annie wishes to return to complete activities, such as catching the bus that she previously completed for herself. She is frustrated

therefore that her son continues to accompany her instead of allowing her to complete the activity independently.

The data in the sub-theme of 'value of independence' was also evident amongst participants wishing to complete the most basic ADLS. Malcolm was admitted to the AMU following a fall, and after experiencing several previous falls had moved into a care home. Although Malcolm provided a muddled account, he did express a wish to be independent with washing, showering and using the bath. He stated:

"I mean, I mean a lot of times, I used to tell them [care staff] when I was going for a wash and that, but you try to do things for yourself..." (Male patient, age 89, TA).

Although in a care home and supported by the care home staff, Malcolm still expressed a preference for completing his own ADLs.

However, it is noted that the data in this sub-theme did reveal an inconsistency. This is demonstrated by Beryl's narratives. Beryl was admitted to the AMU after experiencing chest pains, and this followed on from an earlier heart attack. Beryl had lived with her husband, until he suffered a brain haemorrhage, and eventually needed nursing home care. Her family then took over helping Beryl with the ADLs previously completed by her husband such as shopping, transport to appointments, managing the finances, and making telephone calls. One of her narratives is provided below. This is an interwoven narrative between Beryl and her daughter:

I couldn't do it now

C : Prior to Dad's er, brain haemorrhage in 2001

Dad managed all the finances.

Pt : He did everything, yer.

C : And was very much

did all that sort of stuff.

And then after he had that

we taught Mum how to write cheques and all

and you know deal with all that sort of thing

and then she just lost

I think she was doing a lot more for herself

- and then she had a heart attack a couple of years ago*
- and she kind of gone a little less confident*
- Pt : *Yer, **I felt better** [emphasised],*
yer, before I had that heart attack,
I mean I was doing things that I wouldn't have done
before, wasn't I? (Evaluation).
- C : *A lot of things, yer.*
- Pt : *That was taking your dad on holiday*
which was a trial
things like that.
- C : *You were prepared to organise things,*
and you were managing money
and all those sorts of things.
- Pt : ***I wouldn't do it now** [emphasised]*
I wouldn't do it now
Couldn't do it now (Evaluation).
- (Female patient, age 80 & carer, NA).

It is interpreted from the final evaluation component of this narrative that Beryl is more comfortable being dependent rather than independent with her ADLs.

In summary, the data in this sub-theme centred on the participant wish to complete their own ADLs where possible, rather than being dependent on others. There were some exceptions to this rule, but this was only represented by a minority of participants.

Theme 4 Summary

This was a large theme which was united by a central tenet that the patient participants returned home from the AMU with on-going needs. These on-going needs, which included both health issues and ADL needs, had an impact on their informal carers. These carers frequently assisted, or even took over, many of the ADLs, as patients struggled or simply were unable to complete these activities. Yet

the patient participants as a whole expressed a desire to be able to complete their ADLs themselves rather than having to rely on their informal carers.

Theme 5: Stoicism

What the data highlighted in this final theme was that despite the dissatisfaction raised by the patient participants in respect of their care delivery, all of them voiced acceptance or tolerance around shortfalls experienced in respect of their care delivery. The participants were in fact very tolerant and understanding. So on the one hand participants recognised some shortcomings in respect of their care delivery and treatment, but on the other hand were accepting and tolerant of these same shortcomings. They did not want to complain. Instead participants made tolerant, generous, patient, and understanding responses.

The findings in this theme were clustered around four sub-themes: a) Ageing assumptions, b) Modest expectations, c) Minimized needs, and d) Passive acceptance. These four sub-themes are reported below.

a) Ageing assumptions

The findings in this sub-theme revolves around participant comments made in respect of their health. The patient participants perceived that their health was declining as a natural part of the ageing process. They spoke about experiencing more pain, stiffness and immobility and about suffering from memory loss and falls. The patient participants did not have high expectations around improving the state of their health in light of the ageing process, and many appeared resigned to accept that their health would decline, and that there was only so much that hospital staff could realistically do to address this decline.

David spoke about experiencing a whole range of medical conditions, such as problems with his lungs and his blood, prostate cancer, and polymyalgia rheumatica. He said:

"I don't want to stop like this, I mean I'm eighty, I'm eighty one, getting on that way anyway, so I mean whether I can expect to get better or not I don't know" (Male patient, age 80, TA).

David reported some improvement in his level of mobility since his AMU admission, but stated he was not 100% better. He did not feel however, that a 100% improvement in his health was realistic, in light of his advancing age. He attributed 50% of his declining health to his age, and thus anticipated only a 50% improvement rate.

Norma also talked about her health declining as a natural part of ageing:

"I was 80 in July [laughs] and I think I since I feel as though I'm just going downhill [laughs]. After I was 80, but erm no it's erm, I thought it was my other, this hip going but they say it's this [osteoarthritis], I've had an awful lot of backache, but it's the arthritis that's doing it" (Female patient, age 80, TA).

Norma went onto say that she just accepted her health declining as part of the ageing process. She expected to become ill because she was ageing, and as a consequence she had prepared a hospital bag, containing her night dress, toiletries and cosmetics, so that her family could bring the bag into hospital each time she was admitted. Norma stated she had prepared this bag because she was becoming older and likely to need hospital care.

Malcolm, like the above two participants, also spoke about the effect of ageing:

"I feel as if I am getting older, I mean it hasn't done me any good having the falls, it has hurt my body in fact, yes. And I'm, where I wasn't frightened of myself before, I would be, I am a bit now... I have been down [fallen] more than once, but it just that it makes you frightened of being on your own a bit when you, before I was just opposite, I just was, "well I'm quite alright on me own" (Male patient, age 89, TA).

Malcolm referred to his declining health on two further occasions during the interview. He associated his ageing with the need for more support, and recognised that he could no longer safely live on his own, and now needed to reside in a care home.

In summary, the data in this sub-theme centred on the patient participant perception that their health was declining as part of the natural ageing process. The participant expectations were modified in light of their perceptions of the

ageing process, and indeed, as revealed in the sub-theme below, participants had modest expectations.

b) Modest expectations

The findings in this sub-theme revolve around participants' modest and sometimes low baseline expectations. The participant comments implied that they had pre-conceived perceptions about the level of care and treatment they would receive in a busy NHS service, based on previous hospital experience and on the societal narrative around acute hospital care. Their comments suggested that they expected the Unit to be busy, noisy and full of very sick people. Likewise they anticipated there would not be enough beds, that they would have to wait for long periods, and that there would be insufficient staff for patient numbers. These expectations arose in response to what had been seen or heard through family and friends, seen and heard via the media, or seen on television programmes. The participant modest baseline expectations meant that they were often pleasantly surprised if the care surpassed their basic expectations.

Leonard did not have high expectations about his hospital care. The extract below has been selected as an example of a participant's modest or perhaps realistic expectations:

Int: "Did you have any expectations about what it would be like in hospital this time"?

Pt: "No, I just take it as it comes. I don't expect the earth, I don't expect anything, I just take it, life as it comes in hospital. Going in to be treated, and hopefully improved, and they do their best to keep you going, so er that's about all there is. Unless you want anything else" (Male patient, age 87, TA).

Leonard spoke about the poor media press concerning the care of older people in hospitals, and about hearing other people moaning about the standard of hospital care. He went on to voice that perhaps he had been lucky with the standard of care he received on this particular occasion. (See Leonard's earlier narrative under the 'Staff Recognition' theme, page 78, in reference to feeling lucky).

Likewise Grace voiced that she had been lucky with the care she had received up until now, but suggested that she might be less fortunate on another occasion. Grace expected the AMU to be busy and noisy, with patients coming and going all

night, and thus accepted that she could not sleep whilst on the Unit. Like Leonard, she also spoke about the poor media image of hospital care for older people, and about hearing about poor standards of care for older people from others:

I know that was true

*... I have heard, erm, from my cousins in Wales,
erm when their mothers were in hospital
they had things that weren't right,
one one of my aunties was left in her wet nightie
and her daughter was going up two or three times a day
to change her, you know,
so I do know that was true (Evaluation),
and also I know about the drink,
on the trolley,
because my aunt Freda,
she couldn't get to the trolley
to bring it up and get the water,
so I do know that erm,
when Vera,
my cousin used to go
and she say "oh I'm parched",
and of course, but they are,
if they could get somebody to just check on that
erm, you know, but it's so hard (Evaluation).*

(Female patient, age 79, NA).

Grace wished to redress the poor image of hospital care for older people, and went onto write to the hospital to thank them for her care.

Annie also spoke about being happy and satisfied with her care, and like many of the other participants stated that she had no complaints. The narrative below has been selected as it highlights her modest expectations:

I didn't expect it

Erm in first time in the morning she [nurse] said have you got any towels?

*So I said "no I've just been brought in",
"do you want a towel and ... toothpaste and everything like that?"*

*And I said, "oh yes please",
and she went and brought all the stuff for me,
was very pleased with that,
and so I say I had got nothing at all,
I thought that were great. I didn't expect it.*

So I was very pleased with that (Evaluation).

(Female patient, age 78, NA).

Annie was pleasantly surprised when the staff met her basic physiological needs, such as providing toiletries, and this suggests that Annie had modest and perhaps realistic baseline expectations. Her comments suggest that these expectations arose in response to previous hospital experiences. When expectations are modest, and these expectations are exceeded, then satisfaction with care and treatment is likely to be higher.

The data in this sub-theme was made up of realistic and pragmatic quotations. The participant language was often subtle, implying that the care received was just satisfactory. When talking about their care delivery the participants frequently used words such as: "alright", "good enough", "not too bad", "normal", "quite happy", "fine", and "ok".

One of Ida's data extracts has been selected as her transcript was interspersed throughout with subtle language about her care and treatment. When asked about her care and treatment she responded:

"Well I just thought I'd been alright there and that was all"
(Female patient, age 88, TA).

Ida stated that she was “quite happy”, “quite pleased”, and “quite contented” with her care, and voiced that she had not done “too badly really”. She described her care as “nothing spectacular” and “nothing out of the ordinary”.

In summary, the data in this sub-theme centred on the patient participants comments which revealed modest, and perhaps realistic expectations around their care and treatment.

c) Minimized needs

The findings in this third sub-theme revolves around the tendency of participants to minimize their problems. Participants frequently stated that they were not particularly ill by the time they arrived on the AMU, or outlined that their state of health was not sufficient to warrant more than a single day on the AMU. The participants downplayed their illness, and as a consequence did not perceive they needed much care. David and Kath both recognised that there were other patients on the AMU with much greater needs than themselves. They spoke about these other patients requiring constant care and attention. Both participants were aware that they were being nursed alongside some patients with very serious medical complaints. As stated by David:

“I mean I wasn’t bleeding, I wasn’t starving, I wasn’t anything was I? [Looking at wife]. The others wanted more attention, so... there was a lot lot worse than me” (Male patient, age 80, TA).

David voiced that he was a lot fitter than the other older patients being nursed in the same bay, and how he did not require attention to the same degree as these very sick patients.

Kath similarly voiced that she did not need much care compared to the patients being nursed around her:

“I mean those that needed the care got the care, you know, I mean there were quite a few had to be attended to more or less all the time, you know, and I think they were looked after quite well, yer... I mean I was looked after for what I wanted you know, I mean sort of thing, ‘cause I was, once I got rid of that fluid I was alright, you know, so I didn’t need anything else sort of thing, except when I asked for a commode or, and

then I was only there that morning, and half the afternoon”
(Female patient, age 88, TA).

Kath recognised that some of the patients required attention all the time, and like the other participants perceived her illness as minor in comparison.

The data in this sub-theme revealed that the participants downplayed their illnesses in light of those with much more serious complaints around them. From the participant accounts it can be surmised that some of these patients were possibly experiencing life threatening conditions, and participants spoke about these patients being wired up to all sorts of machines. The participant concern about others in greater need may be unique to the population from which the sample was drawn. The participants were transferred to the AMU for ongoing tests and investigations, and were then discharged directly home, some returning home in under 24 hours. In contrast, patients around them, were too sick for discharge, and were being transferred to other inpatient wards. The participants observed that these patients were sicker than themselves, and were accepting of care being diverted to those in greater need.

Freda provides an example. Although this participant was expressively dysphasic she was able to articulate the following response to a question about whether the nurses had met her needs:

“Well as near as possible they can do. You can’t be in the time [sic] all the time. But when I wanted, I had diarrhoea, I just told them and “ohh you’ll have to go, oh I’m sorry I can’t leave you now because I’ve got to see one of the girls or the men” what was very poorly, which I could understand that, but then they came and done what they’d got to do” (Female patient, age 81, TA).

Freda was bedbound, and would have needed a quick response from the nursing staff to provide a bedpan. Despite the distressing nature of this situation, Freda still accepted that there were other patients, with serious complaints, that needed immediate attention from staff.

In summary, the data in this sub-theme centred on how the patient participants minimized their own needs, whilst recognising there were other patients on the AMU with much greater, and often more urgent, needs than themselves.

d) Passive acceptance

The findings of the final sub-theme revolves around the passive acceptance by participants of their care delivery. It was interpreted from the data that the participants adopted a passive role whilst on the AMU. The participants trusted the staff on the AMU and basically felt safe under their care. They just accepted what they were told by staff, did not question their actions or interventions, and appeared happy to delegate all responsibility to the staff for their care.

Passive acceptance was evidenced by both the lack of questioning by patient participants on the investigations and interventions completed on them, and by the lack of complaints made by patient and carer participants when they were dissatisfied with the outcome of the care and treatment.

An example of passive acceptance in regard to investigations and interventions was demonstrated by both Grace and Doris. Both of these patient participants trusted the doctors and did not question their actions. Grace was admitted to the AMU after coughing up blood following an earlier surgical procedure on her throat. Grace accepted without question the request to complete an anal investigation, even though she was unaware of the reasoning behind this investigation:

“...then a young doctor came and said to me erm er “I’ve got something to ask you Grace”, so cause I was asked all sorts of questions, as you know, and he says “erm I be later, back in a little while”. Anyway what he wanted to do was do a test up my bottom, and I said well while I’m here why refuse, you know, I mean erm, possibly everybody in the ward had been, had the same” (Female patient, age 79. TA).

Grace completely trusted this doctor, and like other participants never questioned the reasoning behind the tests or procedures completed on her. This was even the case when these procedures were uncomfortable and unpleasant.

Doris, like Grace had complete faith in those providing her care. She was admitted to the AMU with extreme fatigue which was attributed to raised calcium levels. Doris had been on the AMU before as a result of this condition, and had been

successfully treated on that occasion with an injection to lower her calcium level. Doris spoke about being treated this time with a drip. She stated:

“Erm, she [nurse] put a cannula in and then me arm started to swell up so it had to come out and put it in that arm. And then I had two bags of, I don’t know what it was, I didn’t ask”
(Female patient, age 81, TA).

Doris accepted the intervention without question, even though it differed from her previous successful intervention. It is interpreted that Doris preferred not to know the details of her intervention, and that she simply put her faith in the doctors. Ultimately Doris trusted the doctors to resolve her health problem.

Passive acceptance was also revealed when participants voiced dissatisfaction with their overall care and treatment, but did not vocalise this dissatisfaction to either the healthcare professionals or to the hospital. One example is shown by Leonard. He was admitted to the AMU with abdominal pain which was attributed to urinary retention. Leonard was subsequently treated with an indwelling catheter, which he was informed by the AMU staff would be removed within days. District nursing staff would need to remove the catheter, however it transpired that no communication ensued between the staff on the AMU and the district nursing staff. As a result the catheter was not removed as planned. In the narrative below Leonard reveals that he just accepted the outcome:

I can’t do anything about it

*Pt: I thought well,
three or four days, I can put up with that.*

***But I’m afraid** [raised voice]...*

*Int: So they told you it would be three or four days,
but it’s obviously dragged on.*

*Pt: **Yes, cause I asked** [raised voice],
putting it [catheter] in I said,
“how long’s it going to be in for?”
And she said **“two to three days at the most”** [raised voice].
She said “and you should be quite alright”.*

*But no **information** [emphasised word] was passed to the nurses, er community nurses, or the doctor even, so er anyway that's all sorted out now to the **worst** [emphasised], but er can't do anything about it now (Evaluation).*
(Male patient, age 87, NA).

Leonard was clearly unhappy about the final outcome, and the catheter was still in situ at the time of the interview. He had not complained about the issue to either the nursing staff or to the hospital, and just appeared to accept the situation.

In addition to Leonard, two of the patients and their carers, interviewed together (Beryl/Clare and Charles/Betty) also spoke of negative experiences. Yet none of these patients or carers complained to either the healthcare staff on the AMU or to the hospital. As stated by Betty, one of the carer participants:

"But no, as I say I think we did have cause to complain, but we never complained" (Carer, wife).

Clare, the other carer participant, was vocal about her dissatisfaction throughout the interview, speaking about both her mother's distressing situation on the AMU, and about her frustration with the AMU staff organising the discharge. Clare suggested that had the interview been conducted sooner after discharge she would have been even more outspoken. (See Clare's earlier narrative under the 'Discharge uncertainty' sub-theme, page 73). Yet despite expressing a great deal of dissatisfaction throughout the interview neither Clare nor her mother had made a complaint to the hospital.

In summary, the data in this sub-theme centred on the participants acceptance of their care and treatment. Although some of the participants voiced dissatisfaction during the course of their interviews about the care and treatment, it appeared that no complaints were made either to the healthcare staff or to the hospital.

Theme 5 Summary

The theme of 'Stoicism' underpinned the earlier themes, the findings of which provided some explanation behind the participant's comments in these themes. A lot of the participants were stoical when faced with weaknesses around their care delivery. They did not have high expectations about the level of care that they would realistically receive in a busy NHS hospital, and consequently were pleasantly surprised when the standard of care was higher than anticipated.

Chapter Summary

The participants largely attempted to portray a positive impression of the staff on the AMU. They voiced that the staff were kind, caring and attentive. Likewise, the participants were keen to relay the pleasant attributes of the geriatricians working on the RCT study. Despite this, the participants did observe shortfalls in their care delivery. These shortfalls were in relation to: being monitored and observed rather than treated, constant noise and disturbance, amount of waiting around, uncertainty about when they would be able to go home, and inadequate staff communication. When discussing these shortfalls I perceived participant's language and body language to be commensurate with them wanting to avoid coming across as blaming the staff for the shortfalls experienced. Instead participants apportioned blame to external factors outside the immediate remit of the staff on the AMU. Overall, the participants were stoical, and anticipated problems with their care delivery. Their expectations were influenced by past hospital experiences, and by what they had seen and/or heard from family and friends, and through the media and television portrayal of acute hospital care.

The majority of the patient participants perceived that they returned home with on-going problems; both with their health and with their ability to complete their ADLs. It appeared that the participants' unresolved health issues impacted on their ability to complete their ADLs. These health issues were not resolved by either the AMU admission or by the geriatrician intervention. Participants were largely unable to articulate what the geriatrician had done for them. The findings suggest that the AMU admission, and indeed the geriatrician intervention, was focused just on the presenting complaint, and did not address broader issues. This perhaps supports the participants' modest expectations of health care services. As a result of these

broader issues the informal carers provided a lot of support, either assisting or taking over the ADLs. However the patients on the whole would have preferred to have been able to do these activities themselves.

In the next chapter I reflect on how aspects, such as my role and perceived identity, may have influenced the participant, and my own, construction of the AMU experience.

Chapter Five

Reflexivity

Introduction

This chapter sets out the considerations given to reflexivity during the study. It is recognised that during the research process I adopted three identities: researcher, occupational therapist and patient. Each of these is considered in turn. The effect of these identities on participant disclosure is examined. Finally I present what actions I took in the light of these reflections before concluding the chapter.

The Practice of Reflexivity

This section of the chapter examines the practice of reflexivity, considering its use across the research paradigms. The importance of reflexivity is highlighted in relation to the underlying relativist paradigm of the study, and within this the central role that I played in the production and analysis of the findings is recognised. The transparency afforded by reflexivity is promoted as a means of increasing the credibility and trustworthiness of the study.

Reflexivity has been defined as an awareness and understanding of one's subjectivities in relation to the research (Blythe et al 2013). It differs from the more familiar term of reflection, advocated across many diverse occupations, which involves reflecting back on practice (Etherington 2004). Reflection, as opposed to reflexivity, is used selectively for a particular part of practice, usually when this practice is considered difficult or messy, as a means of improving this practice (McKay et al 2003). It is usually a solitary endeavour unless shared with peers or in supervision (Etherington 2004). Reflexivity on the other hand makes transparent to others the researcher's relationship with the research. It involves recognition of the effect of the researcher on the course of the research process (Lee 2009). This necessitates continual critical self-scrutiny on each and every decision made. It is argued that the researcher's decisions, actions, and their role in the research process should be subjected to the same level of critical scrutiny as the rest of the data (Mason 1996). Ultimately the transparency of thought afforded by reflexivity makes the research authentic and credible to others (Lee 2009).

Reflexivity has many diverse meanings within the literature, ranging from a realist focus on assuring the 'accuracy' and 'authenticity' of the findings, to a constructivist emphasis on the open acceptance of the researcher's involvement in the production of the findings (Gough 2003). As a researcher with relativist leanings, the latter perspective of reflexivity is adopted in my study. This form of reflexivity requires a transparent and honest account about the researcher's own values, assumptions, characteristics and motivations to see how these affect the entire research process (Hall & Stevens 1991).

Researchers within the qualitative tradition recognise the subjective nature of their research and use reflexivity as a means to demonstrate the trustworthiness of their findings (Finlay & Gough 2003). One of the challenges facing researchers is to demonstrate to the reader that their study is both credible and sound within the research tradition that it has been conducted (Ballinger 2004, Hall & Stevens 1991). There is much debate in the literature about the criteria for evaluating qualitative studies. Ultimately the question asked is what makes a study believable?

Traditionally studies have been evaluated on a scientific basis, but many authors have argued that borrowing evaluative criteria from a realist paradigm is problematic (Ballinger 2004, Koch & Harrington 1998). Lincoln and Guba in their 1985 publication were amongst the first to challenge this scientific criterion and established parallel terms to the traditional criteria (Koch & Harrington 1998). However as parallel terms their criteria still essentially revolve around the scientific demands for validity and reliability (Maso 2003). Ultimately these terms rest on the assumption of establishing 'truth', and indeed reflexivity for some qualitative researchers has become a methodological tool for ensuring 'truth' (Finlay & Gough 2003). Researchers from a constructivist tradition would challenge such 'truth' claims, but even studies at the relativist end of the continuum need some form of evaluative criteria to distinguish sound from weak studies (Ballinger 2004). Reflexivity is recognised in this tradition as one means of demonstrating that a research product is believable and plausible (Ballinger 2004, Koch and Harrington 1998, Underwood et al 2010).

In the qualitative literature it has been recognised that reflexivity is essential because the researcher is in fact central to the research product (Finlay 2003, Hertz 1997, Koch & Harrington 1998). It is argued that as the researcher ultimately drives the research study, influenced by his/her own values, histories and interests, they can never be separated from the text. Ultimately the researcher has to make sense of the stories they hear. My experience, assumptions, feelings, and ideals would have all impacted on the research product (Bochner 2001). Underwood (2010) recognises that the researcher either consciously or unconsciously shapes the form and content of the participants' accounts. The participant's voice is effectively filtered through the researcher, who decides which stories to tell, and whose accounts to privilege over others (Hertz 1997). It is these screened accounts that are presented to the reader. It is thus recognised that qualitative data does not passively emerge but rather is actively constructed, in other words meanings are made rather than found in the data (Mauthner & Doucet 2003).

This opening section has highlighted the importance which I placed on reflexivity. It was a practice which I adopted throughout my study. In the following sections I have sought to be transparent about the dilemmas faced and decisions made during the research process. My reflections here are drawn from a reflexive journal that I maintained, as recommended in the literature (Blythe et al 2013, Gough 2003, Lee 2009). In this journal I turned a critical gaze towards the self and reflected on 'what was going on' while researching (Koch and Harrington 1998). This chapter provides an open and transparent account of 'what was going on' during my study.

Multiple Identities

As I was the instrument of data collection, it was important for me to critically consider the positions that I adopted (Blythe et al 2013). My reflexivity gave rise to the realisation that I assumed three identities, that of a researcher, an occupational therapist, and a patient. Each of these identities provided a different lens through which I perceived the data, and each in turn is reflected on below.

Researcher lens

The initial intention of my East Midlands RCT colleagues was to have a qualitative study which would focus on the AMU and geriatrician experience. There were no

plans to explore the older patient and informal carer perspectives of the post discharge experience. However my experience working as a research assistant on the AMU, and my background as an occupational therapist, resulted in my desire to expand the research objectives set out in the faculty protocol. It is recognised in the literature that our own interests are unavoidable and are naturally incorporated into any inquiry. The choices made by the researcher stem from our own predispositions and values and it is therefore important to closely examine the reasons behind selecting a particular phenomenon for study (Koch & Harrington 1998).

Whilst working as a research assistant I recruited patients from the AMU onto the RCT. During this period of time I was frequently concerned about the patient discharges that I witnessed. I perceived that the decision to discharge was often made on the basis of resolving the presenting complaint and the need to empty a hospital bed. In my opinion underlying conditions were frequently over-looked and it was not uncommon for the research staff to raise concern about discharges. As an occupational therapist I was alarmed by some of these discharges, which did not include an assessment of the patient's functional ability. Hence the presenting complaint may have been addressed, but the patient may still have been returning home unable to complete basic ADLs.

I felt so passionately about the unmet needs of older people following an AMU admission that I argued for the need to explore this area as part of the qualitative study. After working on the AMU for several months I proposed extending the qualitative study to include an exploration of the post discharge experience, particularly focusing on ADL needs (the fourth objective of my study). An excerpt from my journal at this time highlights the personal intensity of this issue:

It was an intense meeting... [Name] could not understand the need to include occupations [ADLs], and initially suggested that it could perhaps form a chapter as part of the discussion [of my thesis]... [Name] finally agreed with my ideas. I really had to fight for my proposal and it was not an easy meeting. I felt exhausted by the end of the meeting. But I felt strongly that the research had to mean something to me, and that I could not just do a study about geriatricians. I felt concerned that occupational therapy is not included alongside the geriatrician, and feel there is a

need to research how acute medical episodes impact on occupations [ADLs]. I felt strongly that I wanted a piece of research that I would be proud of as an occupational therapist (Researcher's Journal. 27/09/2010).

Maso (2003) argues that the research question must be 'true' to the researcher, and consequently one that they are eager to find the answer to. He warns that if the question originates from someone else, such as an employer, then it is imperative that the researcher questions whether it represents something of real value to them. Maso (2003) argues that the existence of a 'true' question not only provides the passion, interest and motivation to intensely pursue the subject, but explicitly establishes one's presuppositions. These presuppositions do not indicate preliminary answers, but rather present the motives and background behind the asking of the question. He argues that such subjectivity is inevitable within qualitative research and should not be perceived negatively. I acknowledge here that my professional background as an occupational therapist influenced the focus of my study, and this is reflected on further below. This transparency is considered important so that the reader is fully aware of the beliefs and motives which underlined the research process, and they can then judge for themselves the possible impact of these on the findings.

Occupational therapy lens

I have always been passionate about working with older people, and for the 15 years that I have been practising as an occupational therapist I have worked almost entirely with this client group. During this time I have spent many years working at the acute-community interface, providing rapid response to older patients discharged from acute hospital wards. This experience has certainly influenced my beliefs and assumptions about acute medical care. Like my experience of working as a research assistant on the AMU, I perceived that many of the patients visited had been discharged home without adequate assessment by the acute care service. My perception was one of older patients being assessed purely in respect of their presenting condition with no thought as to its functional implications. The result was patients discharged home who were unable to transfer off their settee, or able to mobilise to their kitchen for food and drinks, or climb the stairs to the toilet. My concerns were supported by what I read in the emergency

department literature, which reported that older people often leave the hospital unable to perform basic ADLs (Hendriksen & Harrison 2001, Runciman et al 1996).

Furthermore I perceived that the relatives of these older patients were often overlooked in the discharge decision. These relatives were often found to be distraught when suddenly faced with the needs of an older loved one dependent on them for their support. They were frequently distressed about how they would manage their loved one's needs, whilst also struggling to meet their own needs and commitments. I perceived that hospital staff often assumed in these situations that relatives would meet the older patient's needs and no consideration was provided around the relative's own needs and other commitments. These reflections were supported by what I had read in the literature, which similarly reported that acute care staff often assume that relatives will meet the needs of the older patient on discharge, and no consideration is given to the informal carer's own needs and commitments (Johnson et al 2001).

As an occupational therapist I felt passionate about raising awareness of the experience of older patients, and their informal carers, following an acute medical stay. I acknowledged through my reflexivity that I expected to hear negative accounts around the patient and carer experience, particularly in relation to unmet needs. I realised that there was a risk through my experience as both an occupational therapist and researcher that I might be more attuned to negative stories. Despite this recognition, I also perceived my professional background as a strength. It has been argued in the literature that the researcher's history and experience might not actually be a negative source of bias, but rather result in a richer understanding of the phenomenon (Gough 2003). Indeed, I cannot and would not, wish to set aside the years of my practice experience which have given me a good understanding of the older population being researched and anecdotal evidence of their concerns.

Patient lens

My perspective of acute medical care was not only influenced by my professional background but also by my unexpected parallel experience of being a patient at the very hospital where I was collecting and analysing my data, not long after the study started. Although I was never admitted onto the AMU, I visited the hospital on

numerous occasions as an outpatient and had several inpatient admissions. This experience invariably impacted on my perspective of the care and treatment provided by acute healthcare professionals. My overall experience was negative, and my reflective journal recorded issues revolving around poor communication, waiting, constant disturbance and feelings of vulnerability. I realised that on the basis of my personal experience, like my professional experience that I expected to hear negative accounts from the participants in my study.

Furthermore I recognised that I perceived my study as an opportunity to disseminate the voice of the patient. Atkinson (1997) warns that researchers can share a misplaced sentimentality and a romantic vision in which they wish to bring about positive change for patients. It is common in these situations for the patients to be perceived as the heroes and the healthcare professionals as the villains. Atkinson (1997) warns that a personal ethic can take over in which the researcher wishes to emancipate the patients. One of the excerpts from my reflexive journal shows awareness of this issue:

Having reflected upon my personal beliefs and assumptions I realise that I need to be open to alternative stores. Older people and their carers may narrate positive stories. Their perspective may not reflect my own. I need to be very aware of my own beliefs and be careful that they do not influence participants. I need to ensure I remain open to new possibilities (Researcher's Journal. 12/04/2011).

Primeau (2003) states that as researchers we make problematic in our research matters that are problematic in our lives. My reflexivity gave rise to an awareness of the possible impact of my personal experience, like my professional experience, on hearing the voice of participants.

Impact of Self on Participant Disclosure

In addition to the three lenses in which I filtered the data I also had to question how my three identities might have hindered or facilitated participants to disclose their experiences in the first place. Other researchers have recognised the dilemma of occupying multiple positions, and have reflected on how these positions can influence participant discourse (Hamberg & Johansson 1999). The impact of my professional identity and patient identity on participant disclosure has been reflected on over the page.

Effect of professional self on participant disclosure

In this section I have sought to be open and transparent about the possible effect of myself as a researcher and healthcare professional, on the responses given by the participants in the interviews. My reflexivity gave rise to concern that my identity as a researcher and healthcare professional may have resulted in participants censoring their responses to some degree. Ballinger (2000) similarly recognised that when interviewing older patients on their experience of sustaining a fall her professional identity may have greatly influenced the accounts of participants. She recounted how her professional attire, the wearing of an identification badge, her liaison with ward staff, and her easy access to patient notes, identified her to participants as a member of hospital staff. Ballinger (2000) recognised that even her interview schedule, asking participants to recount the episode leading up to their fall, reflected the type of questioning participants experienced by healthcare professionals. She concluded that her persona as a professional may have resulted in participants constructing accounts designed to refute suggestions that they were in some way responsible for their fall. In a similar vein I recognised that I was most likely perceived by many of the participants in my study as a healthcare professional. Like Ballinger, I wore professional attire, an identity badge, carried research papers, and asked participants to recount the episode leading up to their admission.

I had concerns therefore that the participants in my study may have perceived me as a healthcare professional who worked at the very hospital being evaluated. This led to a concern that participants may have felt vulnerable criticising the very service on which they were dependent for their care and treatment. All but one of the participants in the study were repeat attendees at the hospital, and as such may have felt vulnerable to any possible negative consequences of criticism. Some of the participants specifically asked about my role at the hospital, and despite assurances of anonymity and confidentiality it is possible that some of the participants were less inclined to be critical in view of their perception that I was a healthcare professional. This is a recognised problem of 'insider research'.

Examples of such problems are provided by Blythe et al (2013) and Hamberg and Johansson (1999), who completed studies as 'insider researchers'. The former

recognised the challenges of insider research when completing their narrative study, stating that in some situations participants may feel uncomfortable talking with an 'insider' and may prefer the anonymity afforded by an 'outsider'. Hamberg and Johansson's (1999) study involved interviewing patients by their own general practitioners. In this study concern was raised about a possible power asymmetry existing between the participants and researchers, which the researchers felt may have hampered their ability to capture participant views and experiences.

Despite these concerns, I also recognised that my professional status may have resulted in the reverse dilemma, with participants actually wishing (either consciously or unconsciously) to emphasise the severity of their problems, rather than to underplay them. One such example is provided in a joint interview completed with a patient and carer. I noted in my reflexive journal how this patient participant had struck me as very dependent during the course of the interview. The extension of the house had been converted into a bed sitting room, and the patient participant was seated on a riser recliner chair and pressure relieving cushion. The carer participant spoke about needing a rotunda (transfer aid) to move the patient between the chair and the bed, and the general impression given was that the patient participant was immobile and very dependent on the informal carer. I was somewhat surprised therefore at the end of the interview when the carer left the room, and the patient participant stood and walked (using a wheeled frame) outside to the garage to show me their art work.

I reflected that one possible explanation for this inconsistency was that the carer participant had recently applied for carer's allowance, something they spoke about during the course of the interview. This application may have resulted in a fear that the allowance could be declined if the patient participant was perceived by healthcare staff to be too independent. Like other participants, the carer participant had directly questioned my role at the hospital, and perceived me as a healthcare professional. Both Finlay (2003) and Ballinger (2000) recognise that participants are engaged in an exercise of presenting themselves to the interviewer, and this may have influenced how the situation was portrayed. I've no doubt that the patient participant had been very dependent as a result of a past stroke, and had indeed needed a transfer aid, and a very high level of assistance. The carer participant had most likely been providing a high level of care, resulting in a significant level of

disruption to their daily life. However it would appear that at the time of the interview that the patient participant had made significant progress, and was now more mobile, and may have actually been in need of less assistance. Regardless of their progress, this couple would certainly still be eligible for carers' allowance, but there may have been concern by the participants about my professional assessment of the situation.

Effect of patient self on participant disclosure

Although I had concerns that in many circumstances my professional status may have hindered participant responses, I conversely perceived my patient status facilitated the telling of stories and experiences. It has been highlighted in the literature that patients often feel vulnerable in the acute medical setting (Sorlie et al 2006), and furthermore that patients in research studies may feel anxious about the way their stories will be interpreted and used (Hamberg & Johansson 1999). As a patient I could relate to these feelings of vulnerability. Like the patients in my study I have repeatedly attended the hospital. My reflexive journal records how I have been reluctant to complain despite repeated poor care and treatment. I have recorded in my journal that friends and family have advised that I complain to the Patients Advice and Liaison Service (PALs), and yet I have never submitted a complaint. I reflected on this issue in my reflexive journal:

Yet despite receiving a really poor service, which may be detrimental to my health, I have not contacted PALs or made a complaint. Why? The answer is simple, I am in the midst of receiving treatment and feel vulnerable. If I complain will this prove detrimental to my future treatment? Will staff respond to me as a complainer, and be cautious, careful and distant with me? ... Given my personal reflection, how can I expect older people, a vulnerable group in society to complain? These participants are in the midst of medical treatment. Many of them return to hospital time and time again. They perceive me as part of the medical establishment. How can I expect them to open up and reveal their issues? (Researcher's Journal. 28/10/2011).

It has been recognised in the literature that the identity of the listener is important when the storyteller determines the elements of a story to tell. This selectivity by the storyteller is largely determined by the relationship between the participant and

the researcher (Blythe et al 2013). My patient identity may have facilitated the telling of stories.

In summary, my reflexivity raised awareness of how the participants responded to my three identities as a researcher, healthcare professional, and a patient, and how their voice was either hindered or facilitated by these identities. In the following section I describe how I responded to these challenges.

Actions Based on Reflexivity

I realised through my reflexivity that the above three identities might have influenced both participant disclosure of information and how I perceived that information. Finlay (2003) states that reflexivity involves recognising these fieldwork dilemmas and describing decisions made. Similarly, Underwood et al (2010) and Maso (2003) argue that reflexivity should be more than just 'coming clean' or being apologetic about our biases. They argue that reflexivity should be used as an instrument to improve the quality of the research. This next section therefore considers the actions taken to reduce the influence of self upon the data.

Personal perception of data

I realised through the process of reflexivity that I expected to hear negative stories and accounts from the participants on their AMU and post discharge experience. There was a risk therefore that I might filter out positive experiences. This is not a unique phenomenon, as when researching organisations the focus is often problem orientated at the expense of appreciation (Ludema et al 2001). Appreciative Inquiry is an approach used to recognise the best in people (Steinbach 2005). It seeks to draw out hopeful and empowering stories as a means of building on what works, rather than trying to improve what doesn't. It is recognised in this approach that the questions asked set the stage for what is discovered later (Reason & Bradbury 2001). To this end the questions on the interview guide were designed to be neutral and non-leading. The aim was to encourage participants to relay their stories of both positive and negative experiences. Identifying the former provides a means of building upon existing good practice.

I realised that even if participants provided both positive as well as negative accounts and narratives there remained a risk that I might focus disproportionately on the negative, when analysing the data. Primeau (2003) points out that the lens in which we filter data leads us to choose, or privilege certain participant accounts over others, and as such it is important to be open and transparent about this filtering process. My reflexivity raised awareness of the need to be actively attentive to alternative stories that highlighted the 'wonderful', the 'caring' and 'helpful' nature of the healthcare staff (Thomas 2010). This ensured that both positive and negative experiences were given an equal amount of attention during the analysis, and resulted in the construction of a positive 'Staff Recognition' theme alongside the themes which identified shortfalls and weaknesses in care delivery.

I also realised that my own presuppositions were heavily evident amongst the data. In my reflexivity I had to ask myself whether my presuppositions reflected my findings. In other words, I expected to find that older patients had on-going needs with their health and ADLs, and that these needs would impact on their informal carers, and hence that is what I found. Furthermore it could be argued that my findings are biased by professional interests, as the presence of unresolved ADL needs implies a need for occupational therapy. I subsequently decided to utilise several quality assurance measures as a means of challenging and questioning my findings. These are discussed in the next chapter.

Impact of self on participant disclosure

My reflexivity also raised concern that participant responses might be influenced by their perception that I was a healthcare professional. Specifically I was concerned that participants might censor their voice, and be reluctant to be critical of their care delivery, when speaking with a healthcare professional. More specifically, I realised that the patients, and their informal carers, might have perceived that I worked as a healthcare professional on the AMU, as well as alongside the geriatricians providing their intervention. This was a particular concern at the start of my study, when I was recruiting patients on the AMU to the East Midlands RCT, alongside completing my own study. Although I never directly recruited any of the interview participants onto this RCT, I was working on the AMU alongside the recruiters. This involved liaising with ward staff, accessing patients' notes, and even conversing

with the geriatrician. It followed therefore that the participants in my study may have seen me working in this capacity, even though I did not directly recruit them. I quickly realised that a potential conflict of interest existed as a result of being a recruiter for the East Midlands RCT, whilst at the same time interviewing these same participants. As a consequence of this concern I approached both the Chief and Principle Investigators. I raised my concerns about the potential conflict of interest and as a result I withdrew from recruiting participants onto the East Midlands RCT. This meant that I no longer worked on the AMU, and was thus not familiar to patients/informal carers when I went out to complete the interviews.

Despite no longer recruiting participants onto the East Midlands RCT, I was still aware that participants may have perceived me as a healthcare professional and may have felt vulnerable voicing any criticisms. Attempts were therefore made to put participants immediately at ease at the start of the interview. This was achieved by several measures: a) patients were informed that I did not work for the hospital and was employed by the University, b) patients were reassured that the interview was confidential, and that I would ensure that they could not be identified by others from the information given, c) patients were informed that only myself or a transcriber would hear the audio recording, and d) patients were informed that their information would be assigned a number, and that their personal details would be removed.

Furthermore I made a conscious decision to use my patient identity, where appropriate, to further put both patients and informal carers at ease. This involved disclosing that I was not only a healthcare professional but had experience of being a patient at the hospital. It was felt that by selectively disclosing some personal information about my own patient experience the participants might feel more comfortable narrating their own experiences. Indeed self-disclosure by the researcher has been advocated as an effective strategy for encouraging reciprocity and collaboration between the participant and researcher (Blythe et al 2013).

One example where my patient status facilitated the disclosure of experiences was provided in another of the joint patient/carers interviews. On my arrival at the patient's home, the carer's body and verbal language suggested some degree of hostility. I reflected that the carer perceived me as a healthcare professional

visiting from the hospital. This carer immediately launched into asking me whether I had actually been a patient (rather than just a healthcare professional) at the hospital. Once informed that I had recently experienced an inpatient stay, the carer was observed to visually relax. This carer then produced many narratives about their mother's poor hospital experience. This example highlights how the revelation of my patient identity facilitated the interview process. My disclosure put the carer and the patient at ease, and it is perceived that this enabled them to feel comfortable enough to produce negative narratives. I suspected that the interview would have been less productive if the informal carer and the patient had simply perceived me as a healthcare professional, rather than as a fellow patient.

This section of the chapter has highlighted the actions taken on the basis of my reflexivity.

Chapter Summary

Reflexivity has been used as a means of providing the reader with an open and transparent account of my research, rather than as a means of evidencing 'truth'. Ultimately it is accepted that participants and I co-constructed the accounts given. However in the end it was myself, as the researcher, who decided on the interpretation. Throughout this chapter I have sought to be both open and transparent about the influences of self, as a researcher, occupational therapist and patient, upon the research process and final research product. I have sought to be transparent about both the dilemmas faced and the subsequent decisions made. Through reflexivity I became aware of particular presuppositions which were evident in my findings. I subsequently adapted my methodology to include quality assurance measures to challenge and question my findings, in an attempt to ensure that the voice of the participant was louder than my own. Specific reflections on the appropriateness of my methodological and analytical choices are discussed further in the next chapter, alongside critical discussion around the substantive findings, and the limitations of the study.

Chapter Six

Discussion

Introduction

This chapter is divided into two parts. Part one of the chapter provides a critical discussion around the philosophical stance and methodological choices made within the study and critiques the methods used. It also considers the limitations of the study. Part two of the chapter critically discusses the findings of the study and situates these within the relevant literature.

Part One: Discussion of Study Design

This section examines the overall study design. It commences with a discussion around the constructivist stance adopted, and the narrative methodology. It considers the implications of the study being situated within a large positivist trial. The section examines how effective the design of the study was in eliciting the 'voice' of the participants.

Constructivist Study

The constructivist approach was judged to be an effective stance which enabled the voices of both the older patient and their informal carers to be heard. This fitted well with the ideological aim of the study which was to hear the voice of marginalised and silenced groups in the acute healthcare system. This philosophical stance was influential in determining the methodology and the methods used, and as discussed below, these were judged to have been effective as a means of gathering data required to meet the aim and objectives of the study.

An interpretive narrative methodology was adopted as a means of encouraging participants to relay their stories around the AMU experience. This methodology is specifically aimed at transforming the interviewer-interviewee relationship into one of narrator and listener (Chase 2005). The participant is given the opportunity to 'hold the floor' to tell their own stories. In this way the participant is given a voice in the research process. Control is effectively handed over to the participant who chooses which stories are important to tell. Riessman (1993) highlights how creating opportunities for narratives requires that the interviewer gives up control, and instead 'follows' the participant. As a consequence the narrator's story may

radically depart from the expected (Chase 2005). Denzin and Lincoln (2008) state that rather than seeing narratives as taking the subject 'off track' they should be perceived as 'the point' being made by the participant.

The need to 'follow' participants resulted in many of the narratives falling outside of the intended focus on the AMU experience. Rather than just focussing on the AMU stay, the participants provided narratives which were often related to their entire illness experience, taking into account not only the present experience, but also past experience, and the anticipated future. Frank (1995) recognises that illness narratives are frequently chronological incorporating the narrator's past health, their present ill health, and their future envisioned health. This fits with the narratives given in the study, which revealed how the illness experience was not perceived as an isolated event. However this does not match the professional perspective of the illness journey, which moves from entering, experiencing, and exiting the health care system (Richardson et al 2007). Instead, the narratives given in the study revealed that the AMU was perceived by participants as 'part and parcel' of a much wider experience. Ultimately the narrative methodology captured concerns that might have been over-looked by the more traditional question and answer exchanges associated with interviews.

At times the narrative methodology was also found to be problematic. Numerous narratives had been expected from the participants in the study. This expectation arose as a result of my experience of working as an occupational therapist at the acute hospital-community interface, where I had observed older patients and their informal carers frequently relaying narratives of their acute hospital experience. However when it came to the interviews only six of those transcribed were infused with narratives. This is not a unique problem encountered when conducting narrative interviews (McCance et al 2001).

One explanation behind the lack of narratives is that narratives are a socially situated interactive performance, produced in a particular setting, for a particular audience, for a particular purpose (Chase 2005). The participants in the study may well have told and re-told stories of their AMU experience to friends, family and even healthcare professionals, but have felt less inclined to relay these stories in the interview context. Mishler (1986) writes of a problematic gap that exists

between the discourse occurring in interviews and the discourse of naturally occurring conversation. This is attributed to the culturally shared understanding of interviews as a particular type of discourse. It is recognised in the literature that there is a global perception of an 'interview society' (Chase 2005, Denzin & Lincoln 2008), and arguably participants around the world know what it means to be interviewed (Chase 2005, Patton 2002). This is attributed to the wide use of interviews on the television, on the radio, in magazines, and in many other forms of social media. Different discourses, such as chatting with friends and family and being interviewed have certain expectations, such as turn taking rules and constraints. It is recognised that narratives necessitate that the narrator takes the 'floor' for longer than the normal turn taking in social conversation, and this may feel less appropriate in interviews than in normal social conversation (Labov 2001, Mishler 1986). As a consequence the assumptions embedded in our 'interview society' may actually discourage participants from providing narratives (Denzin & Lincoln 2008).

Although only a minority of accounts were infused with narratives, these narratives were important in understanding the older person's and informal carer's overall AMU experience. The use of the narrative approach, although not productive for each and every participant, proved highly valuable for those participants who did speak in narrative form. These narratives provided a great depth of information, and as a consequence I would use this methodology again in future studies.

With hindsight, in view of the limited number of participants who spoke in narrative form, the combined use of broad narrative eliciting questions and a semi-structured interview guide proved fundamental. The latter was advantageous for those participants who were less inclined to narrate their experiences, and were more comfortable providing short and succinct responses. Equally it was recognised that despite my best intentions to hand control of the interview over to the participant, that some participants might actually prefer and indeed expect the interviewer to take control. I was anxious to ensure that the voice of each and every participant was heard, regardless of whether they were inclined to give narratives. The combination of narrative and opinion/view questions was therefore effective in capturing the voices of the entire sample and I would combine such questioning approaches in similar future studies.

Constructivist Study Embedded within an RCT

The study was embedded within a large RCT, and this served as both a facilitator and a hindrance to hearing the voice of the older patient and informal carer. The central issue here was my role as an 'insider researcher' with the acknowledged strengths and weaknesses bound up in this position (Blythe et al 2013, Unluer 2012).

In many ways the nesting of the study within the large RCT provided a useful position from which to explore the patient and informal carer experience. It provided convenient access to participants, who were identified by research assistants who were recruiting to the RCT. To have independently identified these participants would have been an extremely time consuming venture, and unrealistic for me to achieve as a lone researcher. On this basis I perceived the positioning of the study within the large RCT to be beneficial as it provided a convenient means of identifying potential participants for the study.

The association of the study within the RCT also assisted in the recruitment of participants to the study. This was evidenced when I telephoned potential participants following their discharge. Their initial comments and tone of response suggested the receipt of many cold calls and a general reluctance to engage with such callers. However they were put at ease when it was explained that the study was associated with the RCT. I suspect it would have been more problematic recruiting participants post discharge without this association. Blythe et al (2013) has similarly recognised the value of being an 'insider researcher' when attempting to access and establish rapport with marginalised groups, such as with older people (Koch 1998).

Although my 'insider role' gave convenient access to participants it was also recognised that this same role may have been detrimental to the actual interview process, as participants may have felt vulnerable disclosing information. Indeed it has been recognised in the literature that far from assisting rapport the 'insider' role can actually hinder the giving of information with participants being uncomfortable talking to an 'insider' (Blythe et al 2013, Hamberg & Johansson 1999). This was a concern raised through my reflexivity where it was recognised that participants might have felt vulnerable criticising the very service on which they were

dependent for their care and treatment. It was acknowledged therefore that at the interview stage my insider role may have been detrimental to hearing the voice of the participant, and that a power asymmetry may have existed between myself and the participants.

One way of attempting to overcome this challenge was to interview participants in their home environment, where they were likely to feel more comfortable and less threatened, than if interviewed in the hospital setting. Indeed all the participants did prefer this and upon being interviewed were observed to be relaxed and at ease in their own familiar setting. I was effectively a guest in their home environment and as such there was less of a power asymmetry.

In-depth Interviews

In-depth interviews were also used as a means of reducing the power asymmetry between myself and the participants. In-depth interviews have been recognised in the literature as a means of empowering participants, by giving them more control over what is discussed in the interview (Saks & Allsop 2007). Many authors in the literature have likened this method to a conversation (Mason 1996, Patton 2002, Polit & Hungler 1997), and indeed I sought from the outset to inform the participants that the interview was intended to be informal, and an opportunity for them to 'chat' about their experience.

The loosely structured nature of the first part of the interview guide enabled me to quickly establish a rapport with the participants, and ultimately its informal nature, along with the interview probes, encouraged participants to open up and provide a detailed picture of their AMU experience. This was considered a strength when compared to the less in-depth data that would have been possible from using satisfaction surveys, more commonly used in healthcare to measure patient experience (Lees & Chadha 2011). These surveys are limited by their pre-determined structure, which do not allow for the probing of responses. One major criticism of satisfaction surveys is that they provide an overly optimistic picture of the patient experience, with subjects universally reporting good to excellent levels of satisfaction with their care and treatment. These surveys do not therefore provide a good means of detecting the areas in need of improvement (Bruster et al 1994, Jenkinson et al 2002, O'Connell et al 1999).

Certainly it appeared that participants in the study wished to provide a positive account of their care and treatment, as demonstrated through the 'Staff Recognition' theme. Yet when probed, some of the participants also spoke about shortcomings in respect of their care delivery. It is speculated that this dissatisfaction would not have come to light if these same participants had completed a satisfaction survey. The in-depth interview method therefore afforded the opportunity to progress from gathering narratives to asking semi-structured questions which together provided a deeper rather than superficial account of their AMU experience.

One drawback of the in-depth interview method was the variation in the depth and breadth of information provided across the sample. An alternative method would have been to only utilise a semi-structured interview, asking participants set questions, and avoiding narratives altogether. This method would have provided a greater degree of structure, but by its nature it would have afforded the participants with less freedom over their responses. Ultimately the narratives, generated rich data which complemented and expanded on the views and opinions given by participants during the more focused questions. The benefit of utilising an in-depth method of interviewing was considered to outweigh the drawbacks. A survey would not have achieved the depth of insights that interviews enabled and I would use this combined method again in future studies.

Analysis of the Data

The use of both narrative eliciting and semi-structured questions within the in-depth interviews necessitated two types of analysis: a) narrative analysis, and b) thematic analysis. These are discussed below.

a) Narrative analysis

The narrative data was analysed using the structured analytic framework of Labov and Waletzky (1967). This was in recognition that a structured framework provides a strategy for enhancing the rigor of qualitative studies (Koch & Harrington 1998). It has been stated in the literature that one of the inherent weaknesses of qualitative research is the often omitted detail of how reams of raw data have been developed

into findings (Braun & Clarke 2006). This structured model provides a transparent account on how the narrative data were analysed.

There are several strengths behind this model. Apart from being a model that provides a methodological, structured and systematic means of studying narratives, it is also a widely cited and recognised model of narrative analysis (Mishler 1986). I found the model useful as a means of systematically identifying narratives from the overall discourse in the interviews. This was an important consideration as there is a vast array of definitions in the literature on what constitutes a narrative (Riessman 1993). Once narratives were identified the model also proved helpful in providing a clear and systematic method for analysing each and every narrative.

There have however been criticisms behind the model. One concern raised in the literature is that the model is too narrow (Chase 2005, Riessman 2008). This criticism is centred on the tight focus of the model, which analyses the content of individual short stories, whilst neglecting any attention to the holistic content of narratives across an individual's interview. To address this criticism I expanded the analysis to incorporate an intra-interview analysis. This involved searching for story coherence within each of the interviews. In this way strings of narratives were identified within each interview. Frequently there were repetitive themes across these strings of narratives, highlighting the overall concerns of each participant. This method of analysis has been adopted elsewhere as a means of examining not just individual narratives, but also the 'linked stories' within an interview (Hill Bailey & Tilley 2002). Ultimately I found that by expanding the model to incorporate these 'linked stories', a deeper and more holistic picture was constructed about the participant's experience. Rather than being constrained by the model, I again adapted the approach to meet the needs of the study.

b) Thematic analysis

Most of the data permeating the interviews were in a non-narrative format, composed of description, explanation, and question and answer exchanges. Indeed only six of the transcripts were infused with narratives, and even these transcripts comprised a lot of rich non-narrative data. Thematic analysis was utilised to capture the generalised discussion which fell outside of the remit of

narrative data. As with the narrative analysis, a structured thematic analysis model (Braun & Clarke 2006) was utilised, thereby promoting transparency as to how interpretations were arrived at. The model provided clear guidelines and ensured I followed a rigorous and thorough approach to analysis without being overly constrained.

McCance et al (2001) in their study of acute hospital care similarly utilised both narrative and thematic analysis. It was recognised in this study that although the primary focus was upon obtaining patient and nurse narratives, there was a risk that vast amounts of rich data would be lost if reliant on narrative analysis alone. Furthermore, the authors of this study reported that, like in the present study, they found that patients, despite prompting, did not produce any narratives. If utilising narrative analysis alone, it was recognised by these authors, that the entire data from across these participants would have been incomplete.

The combined use of both thematic and narrative analysis gave me confidence that I had captured the majority of available interview data. This combined form of analysis increased the depth and completeness of the findings, and I would utilise both methods of analysis in any similar future study.

Quality Assurance Measures

The two analytic approaches discussed above provided methodological triangulation, enabling the data to be analysed from two different perspectives. This prevented me from jumping to premature and possibly ill-founded conclusions. Miles and Huberman (1994) warn that as most qualitative researchers work alone, they act as a 'vertical monopoly', from defining the research problem, through to the interpretation of data and the writing up of their findings. They advise therefore that the lone researcher uses various tactics to test and confirm their findings, thereby ensuring the trustworthiness of the findings generated. These authors write from a realist perspective, and certainly one's orientation has an impact on the importance ascribed to quality assurance measures. Researchers from the relativist end of the research continuum would argue that as reality is constructed there is no one single underlying truth against which research can be measured. Rather it is assumed that findings will vary (Ballinger 2004). However as an extreme form of relativism was not the goal, and in recognition that I was working

as a lone researcher, I felt it was imperative that some quality assurance measures were adopted, to demonstrate trustworthiness. This was achieved through: a) data display tables, b) a search for disconfirming evidence, and c) the blind reading of narratives. These three methods enabled me to question, challenge, and to verify the results and conclusions. Each of these quality assurance measures is discussed below.

a) Data display tables

The data display tables were used as a complementary strategy to examine and question the patterns emerging from the earlier thematic and narrative analysis (see Appendices 3a-3j). They provided a further means to transparently analyse the data (Williamson & Long 2005). These tables enabled me to present the data in a condensed matrix format providing an expedient way to draw the reader's attention to the overall trends across the data (Averill 2002). One recognised weakness of qualitative analysis is the difficulty in presenting the vast amounts of data necessary for the reader to evaluate the conclusions drawn. Marsh (1990) recognised this dilemma and wrote of critical readers being unconvinced about the trustworthiness of qualitative findings if insufficient data is presented. Indeed in the present study it was not possible to present all the quotations and narratives for each and every theme, and thus only carefully selected data is presented. However, the data display tables have provided a format in which to present the copious amount of data, thereby providing transparency by illuminating the route from analysis to conclusion drawing.

I found the data display tables especially useful for methodological triangulation. It provided confirmation that the findings from the thematic and narrative analysis were both sound and rigorous. Although it was a time consuming method, the approach enabled me to condense large amounts of data, and through this process I questioned and challenged my findings. On this basis I would use these tables again as an adjunct to other qualitative methods.

b) Search for disconfirming evidence

The second method used to challenge and question the interpretation of the data was to search for disconfirming evidence. This is a recognised strategy for challenging the presuppositions held by the researcher (Miles & Huberman 1994). It requires the questioning of preliminary conclusions and searching of the data for any inconsistencies to these conclusions. An example of disconfirming evidence was found in the 'Value of independence' sub-theme, with one of the participants' narratives revealing that they preferred to be dependent, rather than independent.

It was tempting at this stage to simply abandon the sub-theme, and consider the theme a result of my presuppositions. However Miles and Huberman (1994) warn against discarding one's own original hypothesis too quickly just on the basis of a single instance of disconfirming evidence. They state that a single instance does require consideration and evaluation, but ultimately the proportion of negative to positive evidence is the most important consideration. Similarly Braun and Clarke (2006) recognise that a pattern in qualitative data is rarely represented by all the participants, and indeed is frequently contradicted. They state that a weak analysis does not consider these contradictions. Using the data display approach I returned to the data to examine both the frequency and strength of the 'Value of independence' sub-theme (see Appendix 3h). This revealed that there were indeed some other participants who did not purport a strong desire to be independent. These participants were in the minority, but together raised speculation as to the strength of the sub-theme. This led to the conclusion that there was a moderate to strong desire amongst the majority of the participants to complete their own ADLs rather than to be dependent on others. The 'Value of independence' sub-theme was not therefore discarded.

Once again I felt this method was useful for questioning and challenging my findings. I was particularly aware that as a lone researcher, collecting and analysing all the data independently, that there was a risk that the findings might overly reflect my own beliefs and presuppositions. It was important therefore to look for data which conflicted with my interpretations, thereby challenging them. This is a quality assurance method that I would use again when analysing qualitative data.

c) Blind reading of narratives

The final method used to challenge and verify the study findings was the blind reading of some of the narratives by a supervisor (JT) experienced in narrative analysis. Once read we discussed our respective interpretations, and these largely concurred providing reassurance that the findings were not simply a reflection of my own presuppositions.

It could be argued however that a weakness behind this verification strategy was that my supervisor also had an occupational therapy background. We could both therefore have been biased towards meanings which supported the underlying philosophy and beliefs of occupational therapy. However evaluation of the analysis suggested that both my supervisor and I were open to alternative interpretations which conflicted with the underlying occupational therapy philosophy. Both my supervisor, and I, independently evaluated the narrative relating to the above example of the participant's preference for dependence over independence and arrived at similar interpretations. This evaluation conflicts with the underlying occupational therapy belief expressed by some authors that following illness or injury individuals wish to return to, or reach, their maximum level of functioning (Turner et al 1992).

I found this method particularly useful in light of being a novice narrative researcher. It provided confirmation that my analysis was being completed correctly in line with Labov and Waletzky's (1967) model. Despite this, even now with experience of using the narrative model, I feel the reading of a selected number of narratives by another is a useful practice. This second person may identify issues which have been over-looked by a lone individual. Hence, like the above two methods, this is considered a valuable quality assurance method to use when working as a lone independent researcher.

Study Limitations

In this final section I consider the limitations which arose in respect of hearing the voice of the older person and their informal carers, as the users of healthcare services. As the ideological aim of the study was to hear the voice of these participants it is important to consider here how successfully their voice was heard. It has been argued in the literature that when reflecting on whether the voice of the

participant has been heard, that by implication this includes those left out (Krefting & Krefting 1991). The sample for the study was limited by the participants available within the RCT population. This population was composed of a homogenous sample, made up of high functioning patients assessed at low risk of re-admission, and participants of white British ethnicity. There were also few carer participants in the population. All these attributes were thus reflected in the sample for the study (see Tables 1 and 2, Chapter 3, page 45-46). Added to this was the difficulty that participants experienced when trying to recall details of the AMU stay. A total of four key study limitations were identified, and these are discussed below.

a) Homogenous sample

As a consequence of the RCT population, the sample for the study was largely homogenous, skewed by patients with high functioning levels (shown by a high Barthel score) and low re-admission risks (shown by a low ISAR score). Ultimately the attributes of the sample were a reflection of the RCT population, recognised in the literature as a high functioning group (Edmans et al 2013). Although the high Barthel scores of the sample suggest a high functioning group, the responses provided by the majority of the participants suggest that assistance was required with their ADLs. One possible explanation behind this discrepancy is that the Barthel assessment is limited to just personal care and mobility, and does not cover a wider range of ADLs such as domestic and leisure activities (Dewing 1992). The participants in the sample struggled with these activities, and it has been recognised in the literature that it is dependence in these very activities which increases the risk of re-admission (Caplan 1998). Consequently, although the sample was heavily populated by patients with high Barthel scores, they were considered to be representative of patients at risk of re-admission.

However one concern was the absence of patients with more severe health problems in the sample, as large numbers of patient participants declined to be interviewed on the grounds of their poor on-going health. Of the 34 patient participants purposively selected for the study 10 patients were lost on the grounds of ill-health. Five of these patients were re-admitted prior to the interview date, and a further five patients declined to be interviewed stating they were too unwell to partake in the process. A limitation of the study was that patients frequently

declined to participate if they were experiencing problems with their health. These participants felt that the demands of being interviewed were too great in light of their poor health. Hence the very patients at high risk of re-admission either declined to participate or had been re-admitted. It is unknown therefore whether the loss of these patients from the sample actually underestimated the extent of on-going needs being experienced by AMU patients.

b) Absence of ethnic minorities

The sample for the study lacked any patients from racial or ethnic minority groups, despite the fact that over 10% of the population in the East Midlands in the 2011 census described themselves as belonging to a non-white ethnic group (Office of National Statistics 2011a). The East Midlands has one of the highest levels of non-white populations, only surpassed by the numbers of ethnic minority populations in London and the West Midlands (Office of National Statistics 2011b). Furthermore it is recognised in the literature that people from ethnic minority groups often experience a greater burden of disease (Redwood & Gill 2013). Yet despite this ethnic minority groups were poorly represented in the RCT population, and thus were not available for the purposive sample. It was acknowledged by the RCT authors that a large proportion of eligible patients declined to give consent, and it was questioned whether these constituted patients from so-called hard to reach groups (Edmans et al 2013). Racial and ethnic minorities have been identified in the research literature as one of the hard to reach groups and are often poorly represented in clinical trials (Durant et al 2014, Moon et al 2014, Redwood & Gill 2013). It is recognised that the absence of ethnic minorities within the sample does represent a limitation to the study and the voices of racial and ethnic minority patients were not heard.

c) Low number of carer participants

The limitations imposed by the RCT population not only impacted on the patient but also the informal carer sample. The number of informal carers in the RCT population was low, with only 26 carers in the intervention group. This may be due in part to how the phrase 'carer' was presented to the patients at the time of recruitment. The phrase 'informal carer' is a healthcare profession term, and may not be recognised by patients. This is borne out by the fact that only eight of the

patient participants in the sample identified an 'informal carer' at the time of recruitment, but interestingly the majority identified either family members or neighbours supporting them with their ADLs during the course of their interviews. It may well have been the case therefore that these patients did not perceive their family members and neighbours as 'informal carers' at the time of their acute medical admission.

Procter et al (2001) similarly noted that only 11 out of 30 older medical patients in their study, were willing or able to name an 'informal carer'. They speculated this was attributed to a lack of understanding behind the implication of the recent medical illness. However this does not explain the lack of carers in the present study, as most of the patients in the sample were repeat hospital attendees and thus more familiar with the implications of illness upon their ADLs. It is more likely therefore that these patients were either unwilling to nominate their carers to take part in research (perhaps believing it to be too burdensome), or that they simply misconstrued the professional jargon of 'informal carer'. As a result of the low numbers of informal carers in the RCT, the final sample for the study was composed of just six informal carers. With hindsight use of the terms spouse/partner/family member may have been preferable to 'informal carer' although this issue was not identified during public involvement to aid the study design.

There is much debate in the literature about what constitutes an acceptable size of a qualitative sample (Guest et al 2006). Generally it is accepted that the sample size is dependent on one's epistemological and methodological perspective (Baker & Edwards 2012). Consequently the number of people required to make an adequate qualitative sample can range from anything from one to a hundred or even more (Adler & Adler 2012). Most of the literature on sample size is theoretical and fails to present evidence behind the author's recommendations. However one study was found which provided evidence to support the recommendations (Guest et al 2006). This study investigated the optimal size of purposive samples when utilising thematic analysis. The findings of this study suggest that when analysing data from a homogenous sample the data from just six participants is enough to identify the main overarching themes.

Although the issue of sample size remains a continuous issue in the literature, Bryman (2012) identifies the most crucial factor as the ability of the researcher to justify their sample size. In this respect two questions were raised, firstly was the carer sample in the present study large enough to identify common themes? And secondly was the voice of the informal carer truly heard?

In response to the first question, although six informal carers were interviewed, and their number can be considered as low, they represented a fairly homogenous group. Furthermore the carer comments were analysed alongside those of the 18 patient participants. The majority of these patient participants spoke of the support needed from informal carers. The final constructed themes arose from the combined sample of both patient and carer participants, and none of the themes were constructed from narratives or extracts given by the informal carer sample alone. The sample was thus deemed large enough to identify common themes.

It is argued that the modest sample size was in fact advantageous, as it allowed a greater depth of analysis to be completed. As already discussed, the data from these carer participants were analysed in considerable depth, with three of the carer transcripts being subjected to both a thematic and narrative analysis. Mason (2012) argues that it is better in qualitative studies to have smaller numbers, analysed in-depth, than larger numbers superficially analysed.

However in answer to the second question, it is acknowledged that although the sample size of six was considered sufficient, like the patient sample, the carers were unrepresented by racial and ethnic minorities, and consequently the voice of the informal carer population may not have been fully heard. With hindsight and in light of the difficulty recognised in recruiting racial and ethnic minorities in clinical trials (Durant et al 2014, Moon et al 2014, Redwood & Gill 2013), the study design could have been improved with a proviso stating that racial and ethnic minority participants could be recruited separately, if absent in the RCT population.

d) Memory recall issues

A final limitation to discuss was the issue of memory recall difficulties. One of the major challenges encountered during the data collection stage was that many of the patient participants reported difficulties recalling information in relation to their care and treatment. There was a predominance of self-reported memory problems

throughout the interview transcripts; although all the patient participants had previously been assessed by the RCT recruiters as having no substantial cognitive problems. Yet 10 patient participants apportioned blame to their poor memory when struggling to recount their AMU experience. This is not an isolated issue, with other research conducted with older people identifying the problem of memory recall following hospital discharge (Arendts et al 2006, Bobay et al 2010, Bostrom et al 1996, Lee et al 1998, Luker & Waters 1993, Richardson et al 2007).

Some of the memory recall issues in the present study were related to the patient's repeat attendance at the hospital. Indeed most of the patient participants indicated that their recall difficulties were specifically tied up with other recent hospital admissions. It appeared from participant comments that details were being confused between the AMU and earlier or even subsequent admissions.

Several strategies were adopted throughout the course of the study to try to address the issue of memory recall. Right from the inception of the study memory recall was anticipated to be a potential issue as a result of concerns raised in the literature, and through discussion with the study's PPI representative. As a consequence the timing of the interviews was set at a maximum of six weeks post discharge. However experience revealed that memory recall problems were still evident in this short time frame, and subsequently an ethics amendment was submitted to reduce this time frame, allowing interviews to be completed from two weeks post discharge.

An additional strategy employed was to interview patients alongside a carer wherever possible, and certainly where a carer was present it was often easier to be confident that participants were relaying information about the AMU rather than to a previous admission. Furthermore my 'insider' experience working on the AMU also served to be beneficial, as I often found that I could distinguish between accounts of the AMU or another admission. To reduce any possible bias resulting from this issue accounts were only included in the analysis if it was believed they directly related to the AMU experience, and where any doubt arose accounts were excluded from the analysis. These strategies served to reduce any potential bias introduced by memory recall difficulties.

Summary of Part One

This part of the chapter has focused on how effective the study design was on hearing the voice of the older patient and their informal carer. It has included critical discussion around the methodology and methods utilized, and debated the extent that each served as a facilitator or hindrance to hearing the participant voice. Consideration has been provided on the learning acquired from conducting this study, and this has included contemplation on whether the methods utilised in the present study would be adopted in any future qualitative research.

Part Two: Discussion of Findings

Part two of this chapter critically examines the five constructed themes of: i) Shortfalls in Satisfaction, ii) Staff Recognition, iii) Nebulous Grasp of Geriatrician Service, iv) On-going needs and, v) Stoicism. Although these findings are local and specific to the East Midlands, they are complementary to wider research completed in the field of acute medical care. The discussion considers both supporting and contradictory evidence in relation to the five themes of the study. The recommendations made on the basis of the findings are provided in the following chapter.

Theme 1: Shortfalls in Satisfaction

The findings in this theme met the first two objectives of the study: One: To explore older patient and informal carer perspectives of the care and treatment received whilst on the AMU, and two: To explore older patient and informal carer perspectives of the care and treatment received relating to discharge from the AMU. The patients and carers perceived shortfalls around their care delivery, both in relation to their stay on the Unit and when being discharged home. This large theme was divided into five sub-themes: a) Perceived lack of treatment, b) Constant disturbance, c) Waiting, d) Discharge uncertainty, and e) Inadequate communication.

a) Perceived lack of treatment

The patients perceived that they received little in the way of treatment on the AMU, and instead spoke about just being observed and monitored by the staff, who took their vital observations and blood, and ensured that the underlying cause of their admission had been stabilised. They were then discharged back home. Healthcare professionals would likely argue that monitoring is a vital part of the patient's treatment. However an important consideration is how patients actually perceive their treatment, and in fact only three of the patients spoke about having received any treatment. Overall it appeared from the patient comments that treatment in their eyes was confined to medication, oxygen, intravenous drips, or injections.

There is a lack of research on the older patient perspective of treatment in the acute medical setting. Only one study was located, but this was completed in a rehabilitation rather than an acute medical setting (Luker & Waters 1993). This study sought the opinions of 28 older patients of their hospital stay. Typically the patients interviewed reported high levels of satisfaction, and only three out of the 20 women, and none of the 8 men, were overly negative about their hospital stay. However two of the three patients who provided negative comments perceived that little had been done for them during their rehabilitation stay. These patients spoke about the lack of medication given to treat their underlying medical condition. Hence, like in the present study, medication was once again associated with treatment by patients.

The patient perspective of treatment is important, because if a patient believes they have just been monitored on the AMU, and their underlying condition has not been treated, then there might be a risk that the patient may re-present at the hospital for the same presenting reason. Interestingly some of the patients in the present study did speak about attending the hospital for the same reason on more than one occasion, and it might be the case that these patients felt their condition was not addressed on the previous admission. This is a politically relevant issue, as the government is now financially penalising hospitals when patients re-present within 30 days of discharge (NHS Confederation 2011). However, it was outside the remit of the study to follow up patients after interview, so it is unknown if any of the patients who spoke of on-going issues with their health and ADLs, re-presented at the hospital following their interview. Regardless of financial penalties, re-admission may result in the distress of the patient (and informal carer), and a cost to the NHS, and thus remains a concern.

b) Constant disturbance

The patients spoke about the constant amount of noise and disturbance that occurred around them both day and night. This noise was attributed to two factors: Firstly, other distressed and disturbed patients on the Unit and secondly, staff activity around these patients, and their discussions. The patients spoke about being unable to relax or even sleep due to the persistent noise and disturbance occurring around them. The findings in this sub-theme are important as constant

noise and disturbance is not conducive to rest and relaxation, particularly important after experiencing an acute medical illness.

It is difficult to address the issue of noise and disturbance created by other distressed and disturbed patients, and to a certain extent such noise and disturbance is inevitable. However it has been recognised in the literature that staff can reduce the amount of noise and disturbance created by others, and this involves being stricter about managing the inappropriate behaviour of patients and their visitors. For example, one study by Jones and Lester (1994) found that patients attributed most noise and disturbance to patients playing televisions at high volume, excessive numbers of visitors, and visiting occurring outside of set visiting hours.

The other issue raised by the patients in the present study related not to the disturbance created by other patients, but rather to disturbance as a result of staff congregating around the nursing stations. Patient notes, the ward telephone, and the hospital computer were situated at these stations, and patients spoke about staff conversing together in this location. A similar issue was raised in an emergency department study (Limbourn & Celenza 2011). Patients in this study stated that they particularly disliked hearing doctors talking about other patients whilst at the nursing station. The authors in this study warn that staff need to be aware that they are highly visible and audible to patients.

The findings of this sub-theme reflect the findings from studies conducted in emergency departments (Britten & Shaw 1994, Coughlan & Corry 2007, Kelley et al 2011). One might reasonably expect that noise and disturbance is an inevitable problem in these departments, as emergency departments are in a constant state of flux with an unpredictable case load of patients. However even on acute wards the problem of noise and disturbance has been reported (Jones & Lester 1994, Care Quality Commission 2013, Webb 2007), as well as in a study conducted on an AMU (Lees & Chadha 2011). The findings of these studies reveal that patients are disturbed both by other patients and by the activity of hospital staff.

Interestingly, all the studies cited above were completed in the UK, and this suggests that noise and disturbance may be a particular issue for patients experiencing an acute medical stay in the UK. This is not surprising as patients

admitted onto acute medical wards are likely to be very unwell, unstable, and distressed. Added to this is the need to constantly admit patients from the emergency department, and to discharge patients to free up available beds. Noise and disturbance in this setting, like the emergency department, can therefore be considered an inevitable part of an inpatient stay. However it has to be recognised that noise disturbance is contrary to the patient's need to rest and sleep, and both are particularly important when patients are acutely unwell. As aptly voiced by one of the carer participants in the present study, a disturbed environment is not conducive to the recovery of an older person who may have experienced a heart attack in the previous 12 hours.

c) Waiting

The patients spoke about waiting throughout their entire AMU stay. Waiting began in the emergency department when patients had to wait for an available bed on the AMU, patients then waited to see the doctor, for tests and investigations, and continued having a sense of waiting right through to the point of discharge. At this point in time the patients had to wait either for permission from a doctor to go home, their medication, the doctor's discharge letter, or hospital transport.

Waiting is once again a common theme in emergency department studies, where much of it centres on patients feeling alone and abandoned (Baraff et al 1992, Elmqvist et al 2011, Kihlgren et al 2004, Nyden et al 2003, Nystrom et al 2003a, Nystrom et al 2003b, Olofsson et al 2012). As a consequence of feeling alone, the patients in these studies spoke of the value of having family members stay with them. This meant that patients were not left alone for hours, and importantly had a means of summoning staff attention (Nyden et al 2003, Nystrom et al 2003a, Nystrom et al 2003b).

Interestingly, although waiting was a sub-theme in the present study, none of the patients spoke about feeling alone or abandoned during their interviews, or about a need for family members to remain with them once on the AMU. This may be attributed to the fact that patients on AMUs are nursed in bays, and not in curtained cubicles or in individual assessment rooms. In this way patients can observe other patients and nurses around them, and they may consequently feel less vulnerable, alone and abandoned. Indeed two emergency department studies (Nyden et al

2003, Nystrom et al 2003b) found that older patients felt more secure when nursed on a trolley in the corridor than when left alone in an examination room. These patients reported a fear of their health deteriorating when left alone, and hence privacy was forsaken for a preference to be visible.

Research studies reveal that patients expect to wait when attending the emergency department (Considine et al 2010, Elmqvist et al 2011, Nystrom et al 2003a, Nystrom 2003b). Yet the fact that waiting arose as a sub-theme in the present study suggests that this issue may not just be confined to the emergency department, but actually extends through to the AMU. Indeed it has been proposed in the UK literature that AMUs have been used as 'holding bays' to ease the queues within the emergency departments, and to prevent breaches of the four hour emergency department target (Munir 2008). However there has been a limited number of studies completed on AMUs, and this makes it difficult to determine whether waiting is an issue across these Units, or just an isolated problem in the East Midlands.

Only one UK paper was found which similarly revealed the issue of waiting on an AMU (Lees & Chadha 2011). However the theme of waiting only arose as a result of brief and superficial comments recorded in two patient diaries. Other studies completed on AMUs have not identified waiting as an issue (Ferguson et al 2013, Mace 1998, Slatyer et al 2013, Sorlie et al 2006, Sullivan et al 2013). However all but one of these studies were conducted outside of the UK (Sullivan et al 2013), and thus may not be relevant to the UK experience. For example, the study by Ferguson et al (2013) was completed in Canada, where the average length of stay on the AMU was recorded as exceeding two weeks. Yet in the UK the average length of stay on an AMU is under 72 hours (Scott et al 2009). The international variation of AMUs makes it difficult to compare the patient experience. There remains therefore limited evidence to date on the experience of waiting on AMUs.

The issue of waiting is an important concern as the perception of waiting has been correlated with patient satisfaction (Considine et al 2010, Elmqvist et al 2011, Watson et al 1999). Although it may be impractical to entirely eliminate waiting on AMUs, studies completed in emergency departments have revealed that the experience of waiting is more important than the actual length of waiting. These

studies have highlighted the need to improve communication around waiting (Baraff et al 1992, Bongale & Young 2013, Coughlan & Corry 2007, Elmqvist et al 2011, Kihlgren et al 2004, Limbourn & Celenza 2011). The authors of these studies suggest that waiting becomes less of an issue once the reasons are communicated by staff.

d) Discharge uncertainty

Both the patients and informal carers spoke of uncertainty in relation to the timing of the discharge. The patients spoke about being unable to relax, expecting at any point in time to be told that they could go home. Even when they were told that they could return home, the patients remained uncertain as to the time that they would be able to leave the AMU, as this was frequently dependent on waiting for a discharge letter, medication, or hospital transport. The informal carers spoke of frustration around establishing the time that patients would be leaving the AMU. As a consequence the carers had to either proactively chase staff on the AMU for information about the timing of the discharge, or conversely they arrived on the AMU to visit their relative only to be told that they needed to take their relative home. The sub-theme of discharge uncertainty was thus equally relevant to both the patients and informal carers.

Discharge uncertainty has not however been an issue widely discussed in the acute medical care literature. Only two qualitative studies were found, one relating to older patients, and the other to informal carers. The first study by Parke and Chappell (2010), revealed that discharge uncertainty was an issue from the perspective of older patients. This study found that the experience of leaving the acute hospital was affected by the rush to vacate beds, with pressure on acute beds often being exerted by the emergency department. The analysis revealed that only after the decision to discharge had occurred did the waiting that the patients experienced during their hospital stay turn to rushing. The patients in this study described the discharge as a 'hurry up syndrome', and spoke of the need to leave the hospital quickly, often before they could organise themselves. The second study, by Foust et al (2012) revealed the theme of discharge uncertainty from the perspective of the informal carer. This study revealed that although the majority of patients interviewed were informed of their discharge, their informal carers often

did not share the same experience. These carers often learnt of the discharge through the patient when visiting, or had to directly seek out staff for information about the timing of discharge.

The theme of discharge uncertainty has not been found in other AMU studies, but as already stated research here is limited. Certainly the AMU provides a unique patient experience, compared to emergency departments and acute medical wards. Discharge is perhaps more uncertain on AMUs, where patients stay for an unspecified period of time whilst assessments and diagnostic tests are completed, and only then is the decision made whether to discharge the patient or admit them onto an inpatient ward. It is perhaps not surprising therefore that the issue of discharge uncertainty arose. However the Department of Health has stated that even in circumstances where patients are waiting for tests and investigations it is still possible for staff to estimate the time of discharge, based on the expected time to complete these tests and interventions (DH 2010a).

It appeared from the findings that neither the patients, nor their informal carers, were given an estimated time of discharge, and this resulted in a lot of uncertainty and difficulty around planning arrangements. Yet the government recognises that discharge is an essential part of care management in any hospital setting (DH 2010a), and as a consequence there has been a lot of attention paid to improving hospital discharges (DH 2003, DH 2004, DH 2010a). A key aspect of this is the early identification of the estimated date of discharge, and the need to communicate this to patients and informal carers (DH 2004, DH 2010a).

Underpinning discharge uncertainty is the need for effective communication between the AMU staff and the patients and informal carers. However inadequate communication was in itself another sub-theme of the study, and this will now be discussed in greater detail below.

e) Inadequate communication

The sub-theme of Inadequate communication is discussed last as it is considered the linchpin of the entire theme. The patients and informal carers spoke about what they perceived as inadequate communication. It is proposed here that had a greater level of communication been exhibited by the AMU staff then the findings in

the earlier sub-themes may never have been raised as problematic issues by the participants.

The sub-theme of inadequate communication revolved around three principle areas; the lack of explanation and information, discussions taking place amongst staff rather than directly with patients and/or informal carers, and a lack of reassurance and apology when events were disturbing. The result of this inadequate communication was that patients and informal carers were left feeling frustrated and anxious. Few of the patients and/or informal carers actually complained about their care and treatment during the course of their interviews, but for those who did, inadequate communication was often at the heart of the issue. Specifically these patients spoke about receiving no apology or reassurance from the staff for the circumstances that they endured on the Unit.

The issue of inadequate communication is not confined to the present study, and in fact appears across other AMU studies, suggesting that communication is an issue on AMUs both nationally and internationally (Lees & Chadha 2011, Mace 1998, Slatyer et al 2013, Sullivan et al 2013). Two examples have been selected to highlight the existence of this issue. In the first study, a qualitative study conducted in Canada, effective communication represented one of the major themes (Ferguson et al 2013). In this study the patients spoke of the need to proactively ask staff questions, otherwise they found that information from staff was not forthcoming. The patients also spoke of the difficulty interacting with staff on ward rounds. These patients expressed concern that their perspectives were not sought, and spoke of decisions being made amongst the staff rather than directly with the patient. The second study, was a complaint audit conducted on an AMU in the USA (Mace 1998). This study revealed that the most frequent complaint made by patients related to staff interpersonal behaviour and attitude. These complaints included concerns that staff were abrupt and rude, implying that staff communication was not perceived as effective by these patients. The issue of inadequate communication also extends to the UK, with studies identifying the need to improve communication between staff and patients (Lees & Chadha 2011, Sullivan et al 2013).

The issue of inadequate communication is an important issue as the literature reveals that good levels of communication are crucial for not only reducing patient anxiety and frustration, but also for improving patient satisfaction (Elmqvist et al 2011, Fosbinder 1994, Watson et al 1999, Wright et al 2013). Importantly, research has found that patients identify communication with nurses as the most important composite of their care. This has been found regardless of the type of illness or hospital speciality encountered by the patient (Elliott et al 2009). However emergency admissions are particularly frightening for patients and stressful for carers, and good communication is therefore a fundamental component of the care for these patients (DH 2003). There is a particular need therefore to provide these patients, and their informal carers, with information on what is to be expected, and to give them the time and opportunity to express their worries and concerns.

The government has recognised that communicating effectively is a core business of the NHS and is the responsibility of every individual healthcare practitioner (DH 2010a). The need for good communication has been recognised throughout the patient journey from admission to discharge, and the importance of patients feeling understood and able to discuss their concerns and worries has been highlighted in governmental policy (DH 2003). The value ascribed to good communication has been demonstrated through the publication of a toolkit produced in conjunction with the government's discharge and transfer policy (2010a). This tool kit has been produced to help individual healthcare practitioners to become better communicators, and to evaluate their communication with patients and their informal carers (Bellew 2010, DH 2010a). This is in recognition that monitoring staff communication is an essential and proven method of improving the patient experience (DH 2010a).

Theme 1 Summary

This theme was composed of five sub-themes. These sub-themes were united by a common concern that staff communication was inadequate. The recommendations made in relation to the findings of this theme, presented in the next chapter, revolve around improving staff communication. Importantly, whilst there are many factors outside the remit of individual members of staff, which might influence the patient experience, staff can seek to improve their own communication. An

important factor is that this action requires little in the way of valuable hospital resources.

Theme 2: Staff Recognition

The findings in this theme met the first objective of the study: To explore older patient and informal carer perspectives of the care and treatment received whilst on the AMU. The participants perceived, that despite the shortfalls experienced in respect of their care delivery, that the staff working on the Unit were very caring, helpful, efficient and attentive. These comments are remarkably similar to attributes expressed in other acute medical studies (Jones & Lester 1994, Sorlie et al 2006, Watson et al 1999).

The positive attributes described by the participants in the present study appear to contradict the findings of the previous theme. However this contradiction of themes is not a unique finding, with other studies conducted in the acute medical literature similarly identifying contrasting themes, between satisfaction and dissatisfaction (Lees & Chadha 2011, Vydellingum 2000). Some of the discrepancy between satisfaction and dissatisfaction might be attributed to the traits of individual members of staff. The participants in the present study valued those staff that responded to and met their basic physiological needs, such as assisting patients with toileting, providing hot drinks, and removing damp and soiled bed linen. Participants singled out individual members of staff on the AMU for praise. This was particularly noticeable in cases where patients had an overall negative experience, but still identified an individual member of staff as caring.

Studies completed in the emergency department have similarly revealed the attributes of staff that are particularly appreciated by patients. Nyden et al (2003) found that patients are more focused on meeting their basic physiological needs, and less interested in higher level needs such as taking part in discussions or decisions about their care. It was interpreted by the authors of this study that older patients attending emergency departments are faced with a frightening and unfamiliar setting, and that in such situations the fulfilling of basic physiological needs is prioritised. Another study by Nystrom et al (2003a) found that patients in an emergency department identified individual members of staff as caring when they spent time with them finding out about their needs. These findings have

similarly been reflected in the AMU setting. In a study by Ferguson et al (2013) patients singled out individual members of staff as caring. These staff were observed to have gone 'beyond the expected'. Appreciation was voiced by patients in this study for individual members of staff that met their basic needs.

The findings in the present study reveal the constituents of good care from the patient and informal carer perspective. This is something that can be elusive and difficult to quantify (McCance et al 1997). This is highly topical considering the recent scandal where patients experienced poor care at the hands of healthcare staff at the Mid Staffordshire NHS Foundation Trust. The Francis Report which investigated this scandal revealed that some of the healthcare staff in this Trust had failed to meet the basic physiological needs of the patients, such as providing food and drinks, and assisting patients with toileting (Francis 2013). A Kings Fund report (2009) has stated that meeting these basic needs forms part of compassionate nursing care. Concern is raised in this report that the need for more technically focused care and the high turnover of patients has contributed to reduced compassion in acute hospital settings (Firth-Cozens & Cornwell 2009). Research has found that patients in the acute care setting not only value the technical skills, efficiency and professionalism of acute care nurses, but also the provision of compassionate nursing (Nakano et al 2008).

The government has set out objectives for the NHS Commissioning board based on the areas identified as being of greatest importance by those using the services (DH 2013a). Importantly this includes transforming how well the NHS performs in respect of providing good care, not just better treatment. It is specified in the NHS Mandate (2013a) that patients should expect to be treated with compassion, dignity and respect. One of the key areas where progress is expected is around ensuring patients have a positive experience of hospital care.

The findings of the present study highlighted the attributes of care that patients and informal carers particularly appreciated in the AMU setting. The participants valued having their basic physiological needs met, and appreciated staff who took the time to sit with them, listen to them, offered reassurance and were empathetic. The findings reflect the government's recognition that the quality of care provided by healthcare practitioners is just as important as the quality of treatment (DH 2013a).

Ultimately the patients in the study valued those staff who demonstrated compassion.

a) Dispersal of blame

Despite the positive recognition of staff, the participants did identify shortfalls in their care delivery, as highlighted in the previous theme. However, where these shortfalls occurred, blame was dispersed away from the staff on the AMU. Instead the participants blamed external factors for the shortfalls, and these fell outside the remit of the immediate AMU staff. The participants perceived that the staff on the AMU were very busy and thus did not want to blame the staff for the shortfalls that they experienced. They spoke about staff rushing around, the constant demand for beds, and the severity of illness of patients being nursed alongside them. The participants blamed the busy Unit on the poor interaction by staff. This poor interaction often resulted in a perception that the staff were uncaring. However the participants did not want to apportion any blame onto the staff and instead spoke about the cut backs that they perceived were impacting on the number of staff and the availability of beds. They were prepared to make allowances for the staff in light of their perception that the Unit was so busy. Indeed some of the participants spoke about feeling sorry for the staff with the pressures that they were expected to work under.

This is far from an isolated finding, as other research completed in the emergency department (Nyden et al 2003, Nystrom et al 2003a, Nystrom et al 2003b) has similarly found that patients blame the busy environment for any dissatisfaction experienced. In these studies patients made excuses on the part of staff for their lack of care due to their perception that the department was so busy. This finding is not just restricted to the emergency department, with two studies conducted on AMUs also finding that patients attributed the busy environment to shortfalls experienced. In both of these studies the busy Unit was blamed for constrained staff communication (Ferguson et al 2013, Slatyer et al 2013).

Workload pressures have been recognised in the literature as an obstacle behind providing compassionate care (Firth-Cozens & Cornwell 2009, Mooney 2009). However although staff may be busy, this does not necessarily need to equate with poor care delivery or constrained communication. It is argued that staff can still

retain a good level of communication whilst working in a busy environment. Research has shown that interpersonal relationships can be maintained in the acute medical environment despite increasing workload (Limbourn & Celenza 2011). A busy Unit therefore does not necessarily need to equate with a lack of compassion or poor staff interactions.

Theme 2 Summary

This theme highlighted the attributes of staff that were valued by the participants. The sub-theme identified that patients and their informal carers were reluctant to blame the staff for any shortfalls that were experienced. The recommendations made in relation to the findings of this theme, presented in the next chapter, revolve around staff identifying with, and adopting, the attributes valued by the participants. Once again this requires little in the way of valuable hospital resources.

Theme 3: Nebulous Grasp of Geriatrician Service

The findings in this theme met the third objective of the study: To explore older patient and informal carer perspectives of the interface geriatrician service. The participants perceived the geriatricians favourably, and like in the above theme, made positive comments about the geriatricians, using words such as 'nice', 'good', and 'charming'. The patients appeared to value the interpersonal skills of the geriatrician, much as they valued the interpersonal skills of those staff singled out for praise on the AMU. As highlighted above, the busy acute medical environment can result in staff spending insufficient time conversing with patients. The patients in the study appreciated the extra attention provided by the geriatrician at the time of their discharge. Part of the role of the geriatrician in the RCT was to set aside time to talk through and listen to the patient's health issues. This may be an aspect of care which staff struggle to provide when busy.

Research studies have found that patients often perceive that they are given little information by acute care staff at the time of their discharge (Coffey & McCarthy 2013, Hesselink et al 2012, Jewell 1993, Knight et al 2011). Spending time with patients has been equated with compassionate care, yet it has been recognised that in the acute hospital setting that time spent with patients has become a devalued activity. Indeed interpersonal care in the acute hospital setting has been

demoted in favour of technical care, and consequently staff can be made to feel guilty if talking to patients rather than completing other 'important' tasks (Firth-Cozens & Cornwell 2009). Yet research suggests that patients benefit from the extra time given by staff to identify their post discharge needs, and from the opportunity to ask questions about their condition/s before leaving the hospital. These patients subsequently feel more prepared to manage at home and have fewer re-admissions (Bobay et al 2010, Coffey & McCarthy 2013). The time spent with the patient at the discharge stage is therefore important.

An important point to make here is that although the patients in the present study provided favourable comments about the individual geriatrician, and appreciated the time spent with them, most were unable to articulate what the geriatrician had actually done for them. They were thus uncertain about the actual purpose of the geriatrician service. This does not mean that the geriatricians did nothing for the patients, but rather that the patients (and their informal carers) were unaware of the details of any intervention. After the geriatrician had seen the patient on the AMU their time was often focused on indirect patient contact, such as liaising with hospital and community healthcare professionals, and making referrals to other services. It appeared in many cases that the patients, and their informal carers, were unaware of this indirect patient contact. Either this information was not verbalised to the patient or the patient was unable to retain the information. Indeed research has found that older people frequently have problems retaining information given to them at the point of discharge (Jewell 1993), especially following an acute illness (Bobay et al 2010). If patients cannot recall, or are not informed of the details of their on-going intervention, they may perceive that nothing is being done to resolve their symptoms, and this could ultimately contribute to the patient re-presenting to the emergency department.

It could be argued that other healthcare staff, not necessarily a geriatrician, could have spent time at the point of discharge discussing the patient's healthcare needs and the management of their condition. The Department of Health literature encourages ward staff to set aside uninterrupted time dedicated to the patient's discharge, and to listen to patient and informal carers concerns and worries (DH 2010a). Indeed concern has been raised about ward staff becoming overly dependent on specialist staff, such as discharge coordinators, completing

discharge responsibilities (DH 2010a, Summerton 1998). Importantly the findings of this theme suggest that patients value the time that healthcare staff spend with them discussing their healthcare needs at the point of discharge. This could be undertaken by geriatricians, but the task would demand less resources if performed by non-medical staff.

Theme 3 Summary

Similar to the previous theme, the findings in this theme highlighted the attributes of healthcare staff that are valued by patients. Specifically, patients appreciated the time that the geriatricians spent with them at the time of their discharge, talking through their concerns and worries. However the patients were largely unaware of the intervention provided, and this may have resulted in them leaving the AMU with a perception of on-going health issues. The recommendations made in relation to the findings of this theme, presented in the next chapter, revolve around staff allocating time to spend with patients at the time of their discharge.

Theme 4: On-going Needs

The findings of this theme, met in part, the fourth objective of the study: To explore how a short stay on an AMU impacts on older patient and informal carer perceptions of their ADLs once back home. The patients spoke about on-going needs following their discharge from the AMU. These needs related to both their health and functional abilities. Where this aim fell short was around establishing whether the stay on the AMU had impacted on their functional abilities.

Regardless, it was apparent from the patient comments that they were experiencing ADL limitations, and these were either new or existing problems. The admission onto the AMU had not resulted in any action to improve their independence with these activities. This large theme was divided into four sub-themes: a) Unresolved health issues, b) Unresolved daily living needs, c) Impact on informal carer, and d) Value of independence.

a) Unresolved health issues

The patients spoke about their on-going health problems. Interestingly many of the cited problems were the same as those which lead to their presentation at the hospital. Hence at the time of the interview, patients spoke about suffering from the

same health issues that had necessitated their AMU admission. This finding is important because patients may re-present at the hospital if their underlying medical complaint has not been resolved, resulting in undue stress for the patient and financial implications for the hospital. The findings of this sub-theme however were not only restricted to the presenting complaint, but also included concerns in relation to other co-morbidities, which similarly did not appear to have been addressed by the AMU admission. Once again these unresolved health issues might result in the older patient returning to the hospital.

The findings of this sub-theme are not an isolated issue. Other studies in the acute medical literature have similarly reported that patients are frequently re-admitted due to a relapse or re-occurrence of the initial presenting medical complaint (Arendts et al 2006, Coffey & McCarthy 2013, Dobrzanska & Newell 2006, Munshi et al 2002, Slatyer et al 2013). Two of these studies, both completed on short stay medical units, have been selected to provide evidence of this similarity. The first was an Australian study which surveyed 596 patients six to eight weeks post discharge. The findings revealed that 29% of these patients had made an unscheduled visit to their general practitioner for the same problem for which they had been admitted, following their discharge. 13% of the sample re-presented to the hospital for the same presenting condition, and 9% of these patients were re-admitted. The authors concluded that a sizeable proportion of patients discharged from the Unit required subsequent medical care for the same problem during the six to eight week time-frame (Arendts et al 2006). The second study was conducted in the UK, and focused purely on older people. This study involved the retrospective examination of re-admissions within 28 days of discharge. The findings revealed that re-occurrence of medical problems accounted for 34% of re-admissions. Specifically 10% of these re-admissions were directly attributed to 'unsorted' medical problems from the initial hospital visit (Munshi et al 2002).

Furthermore, other studies have found that patients discharged from the acute medical setting continue to have concerns with co-morbidities, which like the presenting complaint, were not addressed by the initial admission. Two studies, both completed in Australia, suggest that co-morbidities are not adequately addressed by acute medical admissions. The first study interviewed patients who were admitted for an acute medical complaint, but also suffered from at least one

other co-morbidity. The findings of this study revealed that the acute admission focused on just the presenting acute complaint and did not fully acknowledge or accommodate the comprehensive needs of patients with co-morbidities. This resulted in these patients returning home with no improvement to their co-morbidities (Williams 2004). The second study involved interviewing older patients discharged from an AMU, along with their informal carers, and staff providing their care. The findings from this study revealed that there was limited capacity on the Unit to address underlying chronic health conditions. The focus of admission was thus primarily on the acute presenting complaint. Yet one of the reasons that patients re-presented to the hospital was as a result of their complex health needs (Slatyer et al 2013).

The studies above suggest a failure of the acute medical system in addressing the comprehensive needs of patients, resulting in their re-presentation at the hospital. However it has been argued that older patients may visit their general practitioner, or present at acute hospitals, not because of a failure in the acute medical system, but rather as a result of the common behaviour of older people, who by the nature of ageing are suffering from multiple medical problems. Thus the re-admission rates identified by the earlier studies may simply reflect the norm rather than suggest inadequacies in the acute medical system (Arendts et al 2006). Yet regardless of this argument, research suggests that older patients, admitted for a short length of stay, are at high risk of re-presentation at the hospital (Edmans et al 2013, Dobrzanska & Newell 2006, Woodard et al 2010).

Despite concerns about shorter hospital stays, the Department of Health encourages staff to discharge patients quickly due to the pressure on acute hospital beds. One way of achieving rapid discharge is to complete tests and investigations wherever possible in the outpatient setting (DH 2010a). This means that on-going health problems are often inevitable following an acute medical admission, as many patients will still be undergoing investigations post discharge. It is perhaps not surprising therefore that the patients in the present study spoke about on-going health issues. It was however outside of the remit of the study to explore whether those patients expressing on-going health needs re-presented at the hospital following their interview.

b) Unresolved daily living needs (ADLs)

On-going problems with health were not the only concern raised by the patients. They also spoke about difficulties completing their ADLs post discharge. The patients spoke about experiencing problems completing a whole array of activities including personal care, domestic tasks, and leisure activities. The patients either needed assistance to complete these activities, or relied on others to complete the activities for them.

There is a need to address the ADL concerns of older people admitted onto AMUs, as research has found that functional decline is associated with older patients presenting at emergency departments (Aminzadeh & Dalziel 2002, Caplan et al 1998, Slatyer et al 2013, Wilber et al 2006, Woodard et al 2010). However the focus of acute hospital care is on rapid assessment, stabilisation and treatment. Rehabilitation is increasingly being provided in the community by services such as intermediate care. These services offer short-term interventions by a core team of healthcare professionals, including occupational therapy and physiotherapy, aimed at promoting faster recovery from illness and to increase the confidence of patients to cope once more with their day to day activities (Audit Commission 2000, DH 2001). Importantly, intermediate care has been cited as being particularly effective in breaking the spiral of unnecessary hospital admissions (DH 2001). If patients discharged from AMUs are not referred to these services, there is a risk that they will continue to have ADL difficulties, and consequently be at greater risk of re-presenting at the hospital. Several of the patients in the present study spoke about needing assistance to complete activities due to a loss of confidence, but it appeared that none were referred to the intermediate care service for rehabilitation post discharge.

One concern raised in the literature is that patients in the acute medical sector are disadvantaged when it comes to rehabilitation when compared to other patient groups, such as those experiencing a stroke or hip fracture. Indeed concern has been raised that medical patients experiencing problems completing their ADLs will often receive no form of rehabilitation (Boyd et al 2008). Furthermore, patients experiencing a short length of stay, such as that experienced on AMUs, have been found to be less likely to receive interdisciplinary input from therapists on discharge than patients experiencing a longer length of hospital stay (Mamon et al 1992).

The need for rehabilitation following an acute hospital admission has been recognised in the literature (Aiub et al 2011, Dyas & Thom 2002, McLeod et al 2008). Government policy stipulates that all staff involved in discharging patients should be fully aware of the rehabilitation options provided in the community, and know how to access them (DH 2003). On the AMU where the present study was conducted, the doctors acted as the gate keepers to the therapy services, deciding on an individual ad hoc basis which patients to refer to these services. Awareness about doctors acting as gate keepers to therapy services has been raised in the literature. In one Australian study, large numbers of older patients discharged home from acute hospital wards had ADL limitations post discharge (Clark et al 1997). It was stated that these patients would have benefited from therapy input, yet few were referred to these services. The authors of this study called into question the confidence of doctors to identify patients with likely ADL limitations. This concern is not only limited to doctors, with research revealing that ward staff working in the acute medical setting infrequently seek out information from patients on their ability to perform their ADLs (Bostrom et al 1996, Burns 2001, Farnsworth et al 1995, Hendriksen & Harrison 2001, Williams 2004). This raises concern about the likelihood that patients in need of rehabilitation will receive these services.

It would appear from the findings of the present study that AMU patients were overlooked when it came to rehabilitation services. This may be as a result of intermediate care services being targeted at two principle hospital groups; those patients who would otherwise face an unnecessarily prolonged hospital stay, or those patients at risk of long-term care (Stevenson & Spencer 2002). Neither group were represented by the patients in the present study. However one of the government's outcome indicators, in the NHS Mandate (2013a), is to increase the proportion of older patients offered rehabilitation following discharge from acute hospital services. An opportunity was thus missed to refer this particular group of patients, assessed at risk of re-admission, for rehabilitation post discharge. If patients discharged from AMUs are not referred to these services, there is a risk that they will continue to have ADL difficulties, and consequently be at greater risk of re-presenting at the hospital.

c) Impact on informal carer

In view of the difficulties that patients experienced in respect of completing their ADLs, they were frequently reliant on their informal carers to provide assistance with, or to complete, these activities. Only a minority of patients received help from formal services, and instead where difficulties existed with ADLs it was their informal carers who provided assistance. Unfortunately it was beyond the scope of the study to explore in any depth the extent that the informal carer role was considered a strain or a burden. One limitation behind exploring this area was that the carers were interviewed alongside the patients, and thus the carers may have been reluctant to be open and honest about any burden created by the caregiving role. Despite this their comments did suggest that the caregiving role could be stressful, but they also spoke about caregiving in a positive light revealing that it provided a valuable role.

The literature has predominantly focused on the negative aspects of the informal carer role. This literature suggests that the informal carers of older people experience a whole range of difficulties including worry and anxiety, health issues, and stress resulting from juggling multiple roles (Congdon 1994, Grimmer et al 2000, Johnson et al 2001). However one study was found which suggested that informal carers may actually gain personally from assuming the caregiver role (Lopez et al 2005). In this study 111 informal carers were interviewed, and this revealed that in general there were high levels of satisfaction with the caregiver role. The participants in this study stated that the caregiving role made them feel closer to the patient, and gave sense to their lives. The factors which predicted greater satisfaction were associated with the age of the participant (older carers were more satisfied than younger carers), and by the amount of time that the participant could share with the patient. More satisfaction was experienced by participants who were retired and therefore did not work outside the home.

The effect of caregiving on the informal carer is an important consideration, as research suggests that when older patients experience a decline in their ADLs these tasks are often devolved to their informal carers (Boyd et al 2008, Clark et al 1997, Coffey & McCarthy 2013, LeClerc et al 2002, Popejoy et al 2009). It has been speculated that the support of informal carers enables many older people to continue living at home (Clark et al 1997, McKeown 2007). Research suggests that

informal carers can be highly influential in the decision of older patients to re-present to the hospital following discharge (Coffey & McCarthy 2013, Lotus Shyu 2000, Lotus Shyu et al 2004, Slatyer et al 2013). It has been stated that many informal carers feel unsupported in their caring role and ultimately that this can result in the decision for the patient to re-present at the hospital (Pearson et al 2004). Furthermore it has been identified in the literature that those families in most need of help are in situations where the older patient was admitted unexpectedly or as an emergency (Lotus Shyu 2000), such as in the case of those admitted onto AMUs. It follows therefore that if informal carers feel stressed and under burden by the caregiving role then it is more likely that they will be influential in the older person being re-hospitalised.

Once again, intermediate care services have been identified as a means of offering support to informal carers following an acute hospital stay (DH 2001). The health professionals working for these services can work alongside informal carers offering advice and support around the care of the older person. Where needs are identified that cannot be met by the informal carer these healthcare professionals can refer onto formal services as appropriate. In this way the informal carer is not left alone to manage the needs of the older person post discharge.

The important role played by informal carers has been recognised by successive Governments, and the present Coalition Government has retained the vision set out in the National Carers Strategy (2008b), focused on recognising, valuing and supporting informal carers (DH 2014). Despite this political recognition, at the time the present study was conducted, carers were only eligible for an assessment of their own needs if they were providing 'substantial and regular' care. Although there is no definition behind this criteria, the eligibility required that the person being cared for met the criteria for the provision of community care services (DH 2000b). However the economic climate has resulted in fewer people meeting this eligibility criteria, with the threshold for funded care being restricted by most local authorities to those assessed as having 'substantial' or 'critical' needs (Age UK 2014). As the majority of carers in the present study were providing 'low level' support with domestic tasks, rather than more substantial help with personal care needs, they were unlikely to meet the eligibility criteria for an assessment of their own needs.

It is important to note that the Care Act (2014) has been published since the study was conducted. This act has strengthened the carers entitlement to an assessment, with the eligibility criteria no longer stating that carers need to be providing a substantial amount of care on a regular basis. However, concerns have been raised as to whether local authorities in the current economic climate have sufficient funds to meet the requirements of this act (Merrick & Parker 2014). Furthermore as the vast majority of carers providing 'low levels' of care are not in touch with social care (DH 2014), there is a need for AMU staff to identify carers that may have needs for support, ensuring their needs are met alongside those of the patient.

d) Value of independence

The majority of patients spoke about a wish to complete their ADLs themselves rather than others, such as their informal carers, completing the activities for them. A paradoxical issue thus arose, on the one hand appreciation for support received, and on the other hand a desire to be independent. The patients spoke of a fear of becoming a burden on their informal carers, and expressed a desire to maintain their existing roles.

Other research conducted with acute hospital patients post discharge has similarly revealed a reluctance on the part of patients to become dependent on family members for their ADLs, and specifically anxiety around becoming a burden on their informal carers (Fitzgerald Miller et al 2008, LeClerc et al 2002, McKeown 2007, Mistiaen et al 1997). Rather patients who have experienced an acute illness value regaining their independence with their ADLs (Dyas & Thom 2002, Fitzgerald Miller et al 2008, Gage et al 1997, Slatyer et al 2013). These studies, although completed with patients across a range of ages, have revealed that there is often a strong desire amongst patients to return to 'normalcy' after illness, and this includes recovery of valued ADLs (Dyas & Thom 2002, Fitzgerald Miller et al 2008, Gage et al 1997). In two of these studies, participants specifically spoke of a wish to regain their normal level of functioning through rehabilitation and confidence building activities (Dyas & Thom 2002, Gage et al 1997).

However, it is important to note here that a small minority of patients in the present study appeared to value dependence over independence. It appeared that these

patients preferred support from their informal carers to complete their ADLs. It has to be recognised that some older people may be content to be dependent on their informal carers. This may be associated to a whole range of reasons, but one possible explanation is that many older people spend long periods of time at home with no contact with others and are subsequently lonely. Certainly many of the patients spoke of difficulty getting out of their home to engage with others. It has to be acknowledged that carers, whether informal or formal, who visit the older person to assist or complete their ADLs, provide some social contact. Consequently some older people may be reluctant to relinquish this support in favour of regaining independence.

Two studies completed with older people in the acute medical care literature have highlighted the problem of loneliness. Both of these studies were focused on the first few weeks of recovery following hospital discharge. The first study was completed with six men and five women in Ireland. Six of these patients lived alone, the remainder lived with either a spouse or a sibling. The findings revealed that all the patients that lived alone, as opposed to those living with others, spoke about feeling lonely, to the extent that all of these patients asked if the researcher could visit them again in the future (McKeown 2007). The second study was completed with 14 older women in Canada. The patients in this study spoke of feeling afraid when alone in their homes, especially in the early stage of their recovery. They went on to describe the 'isolating' effect of their recovery from the external world. The findings revealed that these patients had difficulty getting out of their home to do their shopping, banking, or to engage in social and spiritual activities. This resulted in the patients limiting these activities (LeClerc et al 2002). It is possible therefore that although most older people may prefer to be independent with their ADLs, rather than dependent on others, some may forsake this independence in preference to having contact with others, and this may be as a result of feeling lonely and isolated in their home.

Theme 4 Summary

This theme was composed of four sub-themes. These sub-themes revolved around the perception that patients left the AMU with outstanding problems, and this resulted in the need for support from informal carers. However most of the patients

would have preferred to have been independent rather than dependent on these carers. The recommendations made in relation to the findings of this theme, presented in the next chapter, revolve around staff identifying those patients with outstanding needs and making appropriate referrals. In this way needs can be addressed post discharge.

Theme 5: Stoicism

The findings in this theme did not relate specifically to the objectives of the study, but rather provided some explanation behind the older patient and informal carer perspective of the AMU experience. The patients demonstrated a stoic and passive acceptance to what was happening to them in the acute medical environment. Despite recognising shortfalls in their care delivery they were reluctant to complain and instead demonstrated a willingness to accept situations which were far from optimal. This large theme was divided into four sub-themes: a) Ageing assumptions, b) Modest expectations, c) Minimized needs, and, d) Passive acceptance.

a) Ageing assumptions

The patients spoke about their health declining as a natural part of the ageing process. As part of this process they expected to become less mobile and more dependent on others. The patients expressed anxiety and fear about their future projected health and abilities. They anticipated the need for future hospital care, and some even prepared for future hospital admissions by preparing a 'hospital bag' in case an unplanned admission was necessitated. The patients spoke about limits to what could be realistically achieved in respect of their health and recovery in light of their advanced age. Hence although the patients spoke about on-going health and daily living issues, they did not really expect the AMU stay, or the geriatrician intervention, to result in a complete resolution of these issues.

This pessimistic out-look might be attributed to the medicalization of the ageing process, which focuses on the body's gradual deterioration, and has helped to perpetuate a negative discourse around ageing (Higgins et al 2007). This discourse is commonly referred to as 'ageism', which has been defined as 'an attitude of mind', and is evident in both the attitudes and behaviour of individuals, and in the culture and practices of organisations (DH 2010b). Importantly ageism

has been highlighted as an issue across both the health and social care services in England. Indeed the authors of a recent governmental review, conducted into age equality across the health and social care services, reported hearing inappropriate comments made by staff to patients, including comments such as ‘what do you expect at your age?’ (Carruthers & Ormondroyd 2009). Such comments provide evidence of ageist attitudes amongst healthcare staff, and considering these attitudes are held by those providing the care, it is perhaps not surprising that older people themselves accept their declining health and increasing disability as part of ageing.

The issue of ageing assumptions have been found in other studies. Two studies have been selected which provide examples of the existence of ageism amongst both patients and healthcare professionals. The first study conducted in the Netherlands revealed the presence of ageing assumptions amongst both patients and their general practitioners (Eijken et al 2008). This study explored the feasibility of delivering a geriatric intervention programme in the community. Those providing the intervention (geriatric nurse practitioners and geriatricians), and those likely to benefit from the intervention (general practitioners, informal carers and patients) were interviewed. Comments reported in this study suggest, that those likely to benefit from the intervention did not expect great health improvements, as a result of limitations imposed by the ageing process. The second study conducted in Australia explored the attitudes of nurses towards older patients in the acute care setting (Higgins et al 2007). This study revealed that older patients in this setting are marginalised and stereotyped by those providing their care. The nurses interviewed perceived that older patients require more time than their younger counterparts and constituted a ‘heavy’ caseload, with a high need for basic physical care. Furthermore there was a presumption that hospitalisation would not result in a ‘cure’ for the older patient, or alter their quality of life, and their care was thus relegated to a lower priority. It was argued by the nurses that the marginalization process was reinforced by those in positions of power, such as the healthcare planners and managers. These individuals control the hospital resources, and by failing to allocate resources to older people, such as employing geriatricians, were seen to be unwittingly perpetuating the negative attitudes towards older patients.

The presence of age discrimination in the health and social care services in England has been recognised at a policy level with the publication of the National Service Framework for Older People (DH 2001). In this framework an entire standard is devoted to addressing age discrimination in the health and social care sector. A recent governmental review reported that since the introduction of this standard, there have been many examples of good practice, but despite this progress, age discrimination remains an issue. The authors of this report recognised that negative attitudes and narrow assumptions were behind most discrimination (Carruthers & Ormondroyd 2009). It is recommended in this report that ageist assumptions and attitudes, which lead to discrimination, need to be challenged and eradicated. Staff working at all levels of healthcare organisations need to be aware that there are interventions that can improve the health and independence of older people.

There is evidence to suggest that older people are likely to benefit from multi-disciplinary assessment and rehabilitation (Audit Commission 2000). Furthermore, research is particularly promising when the multi-disciplinary intervention is combined with a geriatrician review (Baztan et al 2009, Caplan et al 2004, Ellis et al 2011, Heppenstall et al 2009, Nikolaus et al 1999, Stott et al 2006, Thorsten et al 1999). This evidence needs to be recognised at both policy and service level, so that mainstream services can become established. Frontline staff need to be aware, through training, of the value of referring older people to these services.

b) Modest expectations

The patients expressed modest expectations in relation to their care delivery. This can be explained in part by the nature of the patients in the study, who were largely repeat attendees at the hospital, and were therefore very familiar with the reality of acute hospital care. It could be argued that these patients had realistic preconceptions of hospital care based on their previous experience, and perhaps anticipated weaknesses. Their comments suggested that they expected to encounter a busy and noisy environment, with lots of very sick patients in urgent need of attention. Likewise they expected that there would be long periods of waiting, insufficient beds, and over-worked staff.

The findings of this sub-theme are important because it has been recognised in the literature that if patients have modest expectations, then they are more likely to report higher levels of satisfaction (Danielsen et al 2007, Hordacre et al 2005, Nyden et al 2003, Thi et al 2002). In other words, if patients expect to spend long periods waiting, and to be subjected to delays for tests and treatments, they will be more easily satisfied when their expectations are exceeded. This appeared to be the case in the present study, with patients expressing surprise when they did not need to wait for long periods, and when the Unit was quiet rather than busy.

Other studies have revealed that patients have low expectations of the urgent care system. Two UK studies have been selected to highlight this issue. The first study revealed that participants were often 'pleasantly surprised' when their expectations were exceeded when using the urgent care system. The participants in this study used language such as 'really surprised', 'amazed' and 'impressed' when they were seen quickly by the system, indicating that these participants had expected delays, and conversely when seen quickly their expectations had been exceeded (O'Cathain et al 2008). The second study, explored patients' perspectives around waiting in the emergency department. This study found that there was an acceptance of delays in the emergency department, and an expectation that there would be a long wait to be seen. This expectation arose either as a result of previous personal experience, or through hearing the stories of others who had attended the emergency department. It was concluded by the authors of this study that patient satisfaction with waiting times is directly related to their expectations (Cross et al 2005).

Importantly, research has repeatedly found that older patients are more satisfied than younger patients in respect of their care delivery (Danielsen et al 2007, Jones & Lester 1994), and it has been speculated that this may be attributed to their increased exposure to the health care system. It is argued that older patients often undergo a process of adaptation, whereby they have learnt not to expect too much from the healthcare system (Calnan et al 2003, Hordacre et al 2005, Nyden et al 2003). Indeed all but one of the patients in the present study were repeat attendees at the hospital, and they were therefore very familiar with the acute hospital environment, and this may have resulted in their modest expectations.

The findings of this sub-theme suggest that a patient's evaluation of their care can be positive, even when their care delivery has been poor. This occurs in situations where patients (and their informal carers) have modest and perhaps more realistic expectations of their care delivery. These findings are important as they highlight that feedback received from patients, through commonly used surveys, such as The Friends and Family Test (DH 2013a), may be positively skewed as a result of patient expectations.

c) Minimized needs

The patients spoke about being on the AMU for only a day or 'just in overnight'. They equated their short length of stay with not being particularly ill by the time they arrived on the Unit. The patients often felt that the crisis that had precipitated their presentation at the hospital had been resolved by the time they arrived on the AMU, and subsequently they stated that they needed less care than others around them.

The findings of this sub-theme may be explained by the nature of the patients in the study. These patients appeared altruistic, and this perhaps reflects the nature of people who give up their time for research. Furthermore their beliefs may have been a reflection of the rather unique nature of those patients enrolled into the study. All these patients were discharged directly home, rather than admitted onto a medical ward, as none had an illness sufficient to necessitate a ward stay. Yet patients on AMUs are comprised of not only those requiring a short episode of investigation and intervention before returning home, but also patients with serious medical complaints that will be transferred to a medical ward as soon as a bed becomes available. Thus the patients were being nursed alongside others with very serious medical complaints. It is perhaps not surprising therefore that the patients perceived they had minor ailments compared to others around them. The patients considered themselves fortunate when compared to these other patients, and some of them expressed concern that they might be occupying a bed needed by others with more serious complaints. The patients felt these 'sicker' patients needed the care and attention of staff, rather than themselves, and were thus accepting of care being diverted elsewhere.

The findings of this sub-theme have been reflected in emergency department studies (Britten & Shaw 1994, Nyden et al 2003, Nystrom et al 2003b, Watson et al 1999). The patients in these studies have recognised that there is only a finite number of staff to care for all the patients presenting at the emergency department. These patients recognised that they were only one of many patients, and acknowledged that other patients might have more serious medical complaints than their own. There was a general acceptance amongst these patients that it was appropriate that more urgent patients were prioritised.

The findings of the present study suggest that patients on AMUs, like patients in the emergency department, accept prioritization of care. Thus it would appear that this finding extends further than just the emergency department. Although research on AMUs is limited, one study conducted on an acute care ward in Sweden, similar in set up to a UK AMU, revealed a similar finding (Sorlie et al 2006). The patients in this study recognised that their care was made up of a series of compromises. These patients acknowledged that patients with acute needs should be given priority over themselves, and accepted that they were only one of several patients. Compromises were accepted by the patients in the context of limited resources, and consequently the patients accepted that the staff were busy, that the ward was hectic, and that care had to be prioritised to those with the most acute needs.

The findings of this sub-theme reveal that patients on AMUs accept prioritisation of care. They recognise that they are only one of a number of patients, and that there are a limited number of staff to meet the needs of all the patients. The risk is that patients, with less severe needs, may not fully vocalise all their concerns because they are aware of the heavy demands being made upon staff by more acutely ill patients. Consequently patients may be in a hurry to vacate their bed, so that others with more acute needs can be treated. These patients may then return home with on-going health and ADL needs, and this increases the risk of re-admission.

d) Passive acceptance

The patients presented at the hospital with an acute illness, which is often a frightening experience, and they subsequently placed their lives in the hands of the healthcare professionals. The patients trusted the knowledge and technical

expertise of the healthcare staff, and felt safe in their care. They did not challenge or question decisions made by the healthcare staff, perceiving them as the experts. The patients remained on the AMU until the time that the doctors gave them permission to return home, feeling that at this point in time it was appropriate and safe to do so. Throughout the AMU stay the patients appeared to just passively accept their care delivery, and even when they voiced displeasure about their care and treatment during the course of their interview, there was a general reluctance by the patients to complain about the AMU staff. Indeed even in the few examples where the patients and their informal carers spoke of an overall poor experience, none had complained either to the staff on the AMU, or formally to the hospital.

Ultimately, the patients demonstrated a stoic and passive acceptance towards what was happening to them on the AMU. Other studies conducted in emergency departments have similarly found this phenomenon (Elmqvist et al 2011, Nyden et al 2003, Nystrom et al 2003a). For example, Elmqvist et al (2001) found that emergency department patients assumed a humble attitude, presenting themselves as understanding, patient, and accepting when having to wait for care and treatment. These patients actually developed feelings of loyalty to the staff whom they perceived were working under immense time pressures. This resulted in the patients pretending to be satisfied, when often they were implicitly dissatisfied. Another study by Nystrom et al (2003a) found that whilst the non-urgent patients in this study were dissatisfied with their nursing care, none broached the matter with the staff providing their care. Instead these patients sought to maintain good relations with the staff in order to avoid the risk of making themselves unpopular by complaining.

Research has also found that patient passivity extends beyond the emergency department. Two studies, both completed with older people, highlight this phenomenon. The first study, by Richardson et al (2007), found that patients remained passive throughout their entire hospital journey, from admission through to discharge. These patients did not question the process when transferred from the emergency department to the ward, and instead appeared to just trust in the decisions made by staff. The authors of this study stated that the patients appeared to be accepting of their situation, and despite long periods of waiting, often in uncomfortable conditions, demonstrated a stoic acceptance. The second

study, by Roberts et al (2002) revealed the issue of patient passivity in respect of discharge planning. The patients in this study were found to be content for healthcare staff to make decisions on their behalf in respect of their discharge. They made comments such as “they’re the experts” and “they know best”. All these patients waited for ‘permission’ from the doctor before leaving the ward. The analysis of this study suggested that many of the older patients preferred the healthcare staff to act on their behalf when planning their discharge.

One possible explanation behind the existence of patient passivity relates to a perception by patients that they do not possess the necessary knowledge, skills, or vocabulary to converse with well-educated healthcare professionals. They consequently hand over their care to the healthcare professionals, and trust that they will take care of them (Huby et al 2007, Roberts 2002). It is important however to involve older patients in their care delivery, as this group of patients frequently have long term conditions (DH 2013a), and the policy initiative here is to help patients better manage their own health condition/s (DH 2013a, DH 2013b). One of the objectives in the NHS Mandate (2013a), in relation to long term conditions, is that the NHS will become better at involving patients and their informal carers, empowering them to manage and make decisions about their own care and treatment. Improving patient’s understanding of their conditions improves the outcomes of treatment, prevents deterioration or complications, and potentially reduces avoidable hospital admissions (DH 2013a).

Another possible explanation behind patient passivity relates to the concept of patient vulnerability. Patients experiencing an acute medical illness are often frightened by the onset of the illness, and as a result of this illness are admitted to an unfamiliar clinical environment. It has been speculated that patients in these situations are highly vulnerable, and feel afraid of making a fuss or being a nuisance to the very staff on whom they depend for their care and treatment (Sorlie et al 2006). These patients may be reluctant to complain about shortfalls experienced in respect of their care and treatment, reducing the opportunity to identify problems and improve future care delivery.

Theme 5 Summary

This theme was composed of four sub-themes. The participants were found to be accepting and passive in respect of their care delivery. They did not have high expectations around the staff improving the state of their health or their ADL abilities. They recognised that the Unit was busy and that there were other patients in more urgent need of assistance. They subsequently minimized their own needs. The recommendations made in relation to the findings of this theme, presented in the next chapter, revolve around involving patients in their discharge, and staff identifying with patients the services which might help them improve their health and ADL abilities post discharge.

Summary of Part Two

Part two of this chapter has discussed the five constructed themes of the study. These themes have been critically discussed in relation to other relevant research conducted in the field of acute medical care, and considered in relation to governmental policy. The study adds to the limited evidence on the patient and informal carer experience of AMUs. This is important as although AMUs are only a recently established service, they are rapidly maturing as an established mainstream speciality (Sullivan et al 2013), and as such there is a need to identify both what works and where problems exist in order to improve the patient experience.

The following, and final chapter, outlines the recommendations made on the basis of the findings. These are aimed at improving the patient and informal carer experience, and are directed at the level of policy, management and the individual healthcare practitioner.

Chapter Seven

Recommendations and Conclusions

Introduction

This concluding chapter considers the unique contribution of the study to the existing knowledge in the field of AMUs. This is an emerging field, and to date, there has been limited research into the patient and informal carer experience of these Units. Recommendations are outlined below, made on the basis of the findings of this study.

Unique Contribution

The unique contribution made by this study is an increased understanding of the experience and needs of older patients and their informal carers, as the consumers of AMU services. Importantly, this study not only increases the knowledge pertaining to the older patient and informal carer experience of an AMU stay, but also knowledge concerning their perspective of the post discharge experience. These insights are pressing in view of the proliferation of AMUs in the UK in recent years and the current weak evidence base around older patient and carer experiences of these units. The findings of this study have identified issues in need of addressing, which are summarised in the recommendations below.

Policy and Practice Implications

The pressure on acute hospital beds has resulted in shorter hospital stays, and patients returning home sooner and in poorer health (Grimmer et al 2000, Johnson et al 2001, LeClerc et al 2002). The government has recommended that wherever possible any tests and investigations, of a non-urgent nature, should be undertaken as an outpatient (DH 2010a). The findings of this study reveal that older patients discharged directly home from AMUs have continued concerns around their health and ADL abilities. This suggests that they require a more integrated follow-up service, consisting of not only a geriatrician review, but also multi-disciplinary rehabilitation to address their functional needs. The implication of this is the need for increased governmental funding. However it is known that large

numbers of older patients re-present at emergency departments following short AMU stays (Woodard et al 2010), and this equally has financial implications. Research suggests that the combined input of geriatrician review and multi-disciplinary rehabilitation reduces re-admissions (Caplan et al 2004). The costs of funding integrated follow-up services might therefore be absorbed by the reduced number of older patients re-presenting at the emergency departments. Indeed, one 'hospital at home' service operating in the UK, offering comprehensive geriatric assessments by a multi-disciplinary team, has resulted in a cost saving to the NHS of two pounds for every pound spent on the service (Ward 2014).

Practice Recommendations

Seven key actions are recommended on the basis of the findings of the study. These are focused on both the AMU stay and the post discharge experience. Staff on AMUs, and hospital management, need to consider these actions in relation to the unique features of each and every AMU.

1. AMU staff to be aware of and respond to the attributes of care most valued by older patients.

- These attributes revolve around meeting basic physiological needs and spending time talking and listening to patients. The findings suggest that even when circumstances are out of the control of individual members of staff, such as when working on a busy unit, staff can still improve the patient's experience by maintaining a good level of interaction, and focusing their care around meeting the older patient's basic physiological needs.

2. AMU staff to enhance communication with older patients and informal carers, particularly around treatment and waiting times.

- AMU staff need to be aware that older patients may not perceive the tests, investigations, and monitoring received as being part of their treatment. It is important therefore that staff communicate clearly to older patients the reasoning behind the tests, investigations, and monitoring being completed.
- AMU staff need to be aware of the importance of communicating information about waiting and delays. This should include informing patients/informal carers of the likely waiting time, cause of waiting, what can be expected

during the waiting period, and when they might be expected to be admitted or discharged.

3. Staff to make efforts to reduce the amount of noise and disturbance wherever possible on the AMU.

- Staff to communicate with patients, visitors, or other staff, the importance of minimizing the amount of noise and disturbance, especially at night. Staff to be particularly aware of discussions taking place around nursing stations, if these are situated close to patients' beds. Hospital managers to consider if nursing stations are appropriately situated on the AMU.

4. AMU staff to effect patient and family focused discharges.

- Staff need to set aside time to spend with older patients and their informal carers to discuss their discharge. This time might include discussion around the patient's medical condition/s, their concerns and worries, any discharge medication, how they might feel on discharge, and any follow up tests, investigations and appointments. Management need to promote a culture that values the ethos of staff spending time with patients to discuss their concerns and worries. This can be promoted through staff development and training activities, and through role modelling by team leaders (Firth-Cozens & Cornwell 2009).
- Staff should ensure that the process towards discharge is clear to both older patients and their informal carers. Management could consider such tools as discharge checklists, displayed prominently above patient's beds (DH 2010a, Lees & Delpino 2007). These boards can display the steps towards discharge, the deadlines for tests, investigations and assessments, and the planned discharge date.
- Staff need to provide timely discharge information in written and verbal format wherever possible. This will be especially helpful in light of potential memory recall problems. Management could consider the introduction of discharge folders as a means of providing patients (and informal carers) with their own record of tests and investigations completed, and future plans (DH 2003, DH 2010a).

5. AMU Staff to ascertain the will, ability and preferences of family members concerning the adoption of the role of informal carer.

- Informal carers often support older patients with their ADLs. Staff should not automatically assume that family members wish to take on, or continue, to provide support with these ADLs post discharge. Staff should follow the Department of Health recommendations that state that discharge staff should check on the informal carer's willingness and ability to continue in the informal caregiver role (DH 2010a). This should include consideration of whether the carer would benefit from an assessment of their own needs.

6. AMU staff to consider the patient's underlying co-morbidities alongside the acute presenting complaint.

- Staff should be aware that older patients, assessed as able to return directly home, as opposed to being admitted, may not fully vocalise their health and ADLs needs. Staff need to actively seek out this information from patients and/or informal carers to ensure a thorough and holistic assessment has been completed. Where concerns arise around these co-morbidities, or unmet needs, referrals need to be made to appropriate services.

7. AMU staff to identify older patients that may benefit from medical review and rehabilitation post discharge.

- Staff need to be aware that illness and disability does not need to be an inevitable part of ageing, and that patients may benefit from a medical review and rehabilitation. Staff should take an active role in promoting this message to both older patients and their informal carers. Management could consider providing staff training around shaping positive attitudes, beliefs and behaviours around ageing.
- One way of addressing on-going disability is to refer older patients to existing intermediate care services. Another option, aimed at addressing both disability and illness, is to establish integrated discharge teams. The value of such teams needs recognising at management level, so that these services can be set up and become established as part of mainstream

practice. Staff need to be aware of the value of these services and refer older patients to these services as appropriate.

Further Research

The need for further research was also identified from the findings. It is recommended to explore:

- Perceptions of 'waiting' by older patients and informal carers on UK AMUs.
- Impact of on-going/un-met health and ADL needs on the re-admission rates and experiences of older patients discharged from AMUs.
- Impact of the caregiving role for those providing the informal care of older patients discharged from AMUs.
- Experiences of an AMU stay on patients and informal carers from black and ethnic minority communities.

To date there has been insufficient research around these areas.

Study Conclusion

The constructivist philosophy on which this study was built served well in meeting the overall aim of the study, providing an in-depth understanding of the older patient and informal carer experience of an AMU stay. The in-depth method of interviewing was similarly effective in meeting the four objectives of the study, exploring the patient and informal carer perspective of the AMU stay, the discharge process, the interface geriatrician service, and how they had resettled back home post discharge.

The in-depth method of interviewing uncovered what worked well on the AMU alongside areas in need of improvement. This resulted in seven key areas for action focused on building on the strengths and shortfalls identified in the findings. The latter principally revolved around the importance of good communication by staff and the need for integrated follow up services. Improving staff communication on AMUs may enhance patient understanding of the acute medical illness and the tests and investigations completed, thereby reducing patient uncertainty and increasing satisfaction with the AMU experience. Concerns raised in the study

however, were not just confined to the AMU stay, but continued post discharge. These concerns principally revolved around the precipitating medical crisis, chronic underlying health conditions, as well as functional limitations. It appeared from the patient and informal carer perspective that these needs were not addressed either by the AMU admission or by the additional service provided by the interface geriatricians. Consequently these patients returned home with on-going problems with their health and ADLs which would benefit from improved care management. There is an urgent need to address unacceptable patient and carer experiences and raise standards of care throughout the AMU patient journey.

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Appendix 1 (a)

Literature Search Protocol

A literature search protocol was devised around the four objectives of the study. The aim of this protocol was to ensure that a broad, structured and systematic search of the relevant literature was completed. The primary literature search was based on a time-frame from January 1990 to January 2011. This is a wide time frame but is justified because of the limited quantity of papers published on the patient and informal carer perspective of acute medical care. Gordon et al (2010) systematic review of qualitative studies, completed in the emergency department, similarly adopted this time frame. Likewise, because of the limited numbers of published papers, the search was not restricted to just older populations but included studies of adult populations (providing the sample included participants aged over 65 years). The protocol included keywords for searches as well as inclusion and exclusion criteria. A 'snowballing' approach was also undertaken, whereby the reference lists of these papers were also examined to identify further relevant papers. This was an approach undertaken by Doyle et al (2013), who identified problems with finding papers using the search term of 'patient experience'. A total of 52 papers were located during the primary literature search.

A second literature search took place in-between June 2013 to January 2014. The aim of this search was to identify any subsequent studies completed during the course of the study, and any papers over-seen by the primary literature search. The search terms were expanded for this literature search on the basis of expert advice. A total of 25 papers were located (published in-between 1994 to 2013).

The four literature study aims which guided the search protocol were:

1. To explore the perspective of older people and their informal carers of acute medical care.
2. To explore the perspective of older people and their informal carers of the discharge process from the acute medical care setting.

3. To explore the perspective of older people and their informal carers of geriatrician care and treatment.
4. To explore how a hospital stay impacts on the ADLs of older persons and their informal carers following an acute medical hospital stay.

Step 1: To complete a database search.

In the primary literature search (pre-fieldwork) the following databases were searched:

- Cinahl (Cumulative Index to Nursing and Allied Health Literature). Selected for its focus on medical, nursing, and allied health research.
- Medline (Medical Literature On-Line). Selected for its focus on medical literature.
- ASSIA (Applied Social Services Index and Abstracts). Selected for its focus on allied health research.
- AMED databases (Allied and Complimentary Medicine). Selected for its broader focus beyond just the field of health incorporating literature covering social services and sociology.

In the secondary literature search (post-data collection) the above databases were searched along with two additional databases:

- HMIC (Health Management Information Consortium). Selected for its focus on health services management and social care services.
- NIHR Clinical Research Portfolio (National Institute of Health Research). Selected for the database of research currently being completed across the UK.

Inclusion Criteria

Papers were identified from the above databases by searching for a combination of keywords. These are provided in the table over the page.

Table 1: Inclusion Criteria

Keywords	Combined with:
Patient perspective	Acute Medical Unit
Patient experience	Admission Unit
Patient view	Emergency Admission Unit
Patient opinion	Admission ward
Patient satisfaction	Assessment/Emergency ward
	Emergency Department
Carer/informal carer/caregiver perspective	Hospital inpatient stay
Carer/informal carer/caregiver experience	Acute medical care
Carer/informal carer/caregiver view	Hospital discharge/post discharge/aftercare
Carer/informal carer/caregiver opinion	Geriatrician/physician/consultant
Carer/informal carer/caregiver satisfaction	Activities of daily living post discharge
Additional key words (secondary search)	Additional key words (secondary search)
*Re-admission	Acute Assessment Unit
*Occupational Therapy	Acute Admission Unit
*Multidisciplinary team	Clinical Decision Unit
	Emergency Assessment Unit
	Emergency Medical Assessment Unit
	Medical Assessment & Planning Unit
	Medical Assessment Unit
	Multi-Speciality Assessment Area
	Medical/Emergency Receiving Unit

*Note: the keywords 'readmission', 'occupational therapy', and 'multidisciplinary team' were combined only with the various analogous terms for Acute Medical Unit. The rationale for including these keywords was based on my findings.

Exclusion Criteria

The papers found were excluded from the literature review if the study population was not reflective of the AMU population. See table 2 over the page.

Table 2: Exclusion Criteria

Criteria Description
Studies of patients with psychiatric illness
Studies completed in a rehabilitation setting
Studies completed in a surgical setting or with orthopaedic patients
Studies of stroke patients
Studies of critically ill/palliative care patients
Studies which focus on specific interventions, e.g. pain relief, ventilator care etc
Studies exclusively of adult population: aged under 65 years
Paediatric and obstetric studies
Delayed hospital discharges
Studies completed in Community hospitals
Planned admissions
Doctoral dissertations (non-published work)
Non-English papers
Literature & systematic reviews (focus of critique was on original research papers)

Step 2: Obtain all papers meeting the inclusion criteria, read each paper, and apply the guidelines in table 3 below.

Table 3: Paper Selection Guidelines

Tick box

Appropriate to own research study. Critique paper.	
Inappropriate but useful background information. Retain paper.	
Inappropriate. Discard paper.	

Step 3: Critique each paper.

Critique all papers identified as appropriate (box 1 above) using the Health Care Practice Research & Development critique tool (selecting either the qualitative tool, mixed methods tool or quantitative tool) (Long et al 2002).

Step 4: Synthesise literature.

Synthesise literature for the literature review chapter of the thesis.

Appendix 1 (b)

Qualitative Critique Table

Tool adapted from: Long, A.F. Godfrey, M. Randall, T. Brett, A. Grant, M.J. (2002). The Health Care Practice Research & Development Unit. University of Leeds, Nuffield Institute for Health. Leeds.

Study No:	16
Bibliographic details	Slatyer, S. Toye, C. Popescu, A. Young, J. Matthews, A. Hill, A. Williamson, D.J. (2013). Early re-presentation to hospital after discharge from an acute medical unit: perspectives of older patients, their family caregivers and health professionals. <u>Journal of Clinical Nursing</u> . 22, 314. 445-456.
Phenomena under study/Research question	To explore the perceptions of older patients who re-presented to hospital within 28 days of discharge from an AMU, their family caregivers and health professionals. Rationale: in-depth exploration of the experiences of older people who re-present to hospital soon after discharge from an AMU, and those who care for them, is lacking.
Context	The study was conducted on an AMU within an Australian public teaching hospital. Details on the source population are provided. Details are provided on the Unit. (Differed from the East Midlands AMU, as was staffed by an allied health team). No details are provided on the researchers roles, if any, in the setting. No information is provided on the theoretical framework which guided the study. The authors refer to adopting a narrative approach with patients and family care givers, but narratives are not presented in the findings.
Sample	Purposively sampled older patients (aged 65 years and over) re-presenting to an AMU within 28 days of discharge. Seventy one patients and care givers were approached. The final sample was composed of 12 older patients, 15 family care givers, and 35 health professionals. The latter were nominated by the patients (included hospital and community health staff). Details on the sampling frame are not provided for the health professionals. Excluded patients with cognitive impairment. The characteristics of the sample are provided.
Ethics	Ethical approval was obtained. Participants provided written consent.

Data collection	Interviews were conducted between January and September 2007. Individual audio recorded semi structured interviews were conducted in participants homes or via telephone within three weeks of re-presentation. The Barthel Index was used to assess functional status, and the Network Assessment Instrument was used to assess level of support. The interview schedule is not provided. The researchers state that the interviews with patients and carer givers was based on a narrative approach, asking them to tell the story of how they came to return to the hospital. No further details are provided. The health professionals were asked to describe from their experiences of what lead to older patients returning to hospital. The field work process is insufficiently described.
Data analysis	Data was analysed using thematic content analysis. Some detail is provided. Mention is also made of the use of descriptive statistics. Sufficient quotes are provided to support the findings, and these findings are related to other studies completed in the field.
Researcher's potential bias	No information is provided on the researchers own positions, perceptions, assumptions and possible biases, so it is not possible to determine how these might have impacted on the findings.
Strategies & techniques for enhancing rigor	Several strategies were adopted: <ul style="list-style-type: none"> • Triangulation- interviewed patients, carers, and healthcare professionals • Member checking- with the healthcare professionals • Two researchers examined the transcripts independently

Appendix 1(c)

Evidence Tables

Table 1: Emergency Department Papers

Citation	Locality	Method	Findings
Baraff et al (1992)	USA- 7 states	Large qualitative study. Focus groups. Older people and relatives. Sample size not reported. (Methodological weaknesses).	<ul style="list-style-type: none"> • Attended Emergency Department because they thought their condition was serious and were frightened • Reported Emergency Departments were cold and trolleys uncomfortable • Waited for long periods of time but accepted there were others in greater need • Felt abandoned by staff and valued having family members present
Bongale & Young (2013)	UK	Complaints audit. n= 42 written complaints. Adult sample. (Methodological weaknesses).	<ul style="list-style-type: none"> • Only 42 written complaints received from 106,087 patients attending the two Emergency Departments • Non-clinical issues (63%) accounted for most of the complaints • Half of the non-clinical complaints related to poor communication and staff attitudes/behaviour
Britten & Shaw (1994)	UK	Large qualitative study: n= 83 adult patients. On site interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> • Reported discomfort in relation to the environment and hard trolleys • Reported Emergency Department was busy • Waited for long periods and this was a cause of considerable distress • Felt abandoned by staff and valued having family members present • Aware of other patients in greater need • Spoke of basic needs being met but were not involved in higher level needs

Considine et al (2010)	Australia	Qualitative study: n= 27 older patients and 12 informal carers. On-site observations and post discharge interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> • Reluctance to attend the Emergency Department, and only did so when condition perceived as legitimate • Mixed response in respect of waiting, some were seen quickly and others perceived a long wait
Coughlan & Corry (2007)	UK	Qualitative study: n= four adult patients and three informal carers. Post discharge interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> • Described a crowded, uncomfortable and dirty department • Spoke positively of staff • Perceived staff were busy • Aware of others in greater need
Elmqvist et al (2011)	Sweden	Qualitative study: n= four adult patients, two informal carers, and eight Emergency Department staff. Post discharge interviews. (Robust study).	<ul style="list-style-type: none"> • Feelings of security generated by being in the Emergency Department • Long and uncertain periods of waiting and patients felt abandoned and isolated • Valued having family members present • Reported that staff were busy and as a consequence patients assumed a 'humble attitude' • Patients not involved in decisions
Farnsworth et al (1995)	UK	Small quantitative study: n= 23 older patients. Structured interviews post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • All participants expressed satisfaction with the Emergency Department service • Six (26%) expressed worries about their ability to cope at home on discharge, but none informed the staff of their concerns • Staff were perceived as busy, and this was the reason given for not informing staff of discharge concerns
Frank et al (2011)	Sweden	Quantitative study: n= 356 adult patients. Postal satisfaction questionnaire post discharge. (Robust study).	<ul style="list-style-type: none"> • Patients triaged with high priority needs experienced greater satisfaction than lower priority patients • Reported a low level of satisfaction with meeting basic needs • Older patients were more satisfied and less critical than younger patients • Reported a low level of participation in care

Kelley et al (2011)	Canada	Mixed methods study: n= 5019 older patients hospital records, plus on- site interviews with 56 older patients and nine informal carers, and a further 11 older patients and four informal carers interviewed post discharge. 61 staff interviewed. (Methodological weaknesses).	<ul style="list-style-type: none"> • Spoke of problems with the physical environment • Reported basic needs not met • Reported a busy department • Accepted waiting and recognised others in greater need
Kihlgren et al (2004)	Sweden	Qualitative study: n= 20 older patients observed, and 16 on site interviews. (Robust study).	<ul style="list-style-type: none"> • Spoke of uncomfortable trolleys • Reported long periods of waiting where patients were left alone and felt abandoned • Spoke of busy staff • Any criticism was directed towards management rather than to staff • Spoke of basic needs not being met
Limbourn & Celenza (2011)	Australia	Quantitative study: n= 467 adult patients. On site questionnaire. (Methodological weaknesses).	<ul style="list-style-type: none"> • 93.3% stated their assessment and treatment was good to excellent • Free text responses revealed the attributes of Emergency Department doctors most liked and least liked • The interpersonal relationship between the patient and Emergency Department doctor did not deteriorate as the work load increased
Nyden et al (2003)	Sweden	Qualitative study: n= seven older patients. On site interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> • Participants felt safe in the Emergency Department • Spoke of basic needs not being met and about lying on hard trolleys • Staff perceived as busy and participants did not want to bother them unnecessarily • Recognised others in greater need • Criticism was directed to managers and politicians and not to staff • Participants were not involved in higher level needs such as decision making

Nystrom et al (2003a)	Sweden	Qualitative study: n= 11 adult patients. Interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> • Participants perceived their problem as urgent and felt safe in the Emergency Department • Spoke of long periods of waiting alone • Perceived staff as busy, were reluctant to complain, and instead blamed others such as managers and politicians • Recognised others in greater need • Perception of care dependent on individual staff rather than a collective caring culture • Valued having family members present • Participants relinquished taking part in decisions • Non urgent patients had difficulty making themselves seen or heard
Nystrom et al (2003b)	Sweden	Qualitative study: n= nine adult patients and nine nurses. Interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> • Reported that staff were busy and that participants were left alone for hours • Aware of others in greater need • Valued having a family member present • Perception of care dependent on individual nurses rather than a collective caring culture • Dissatisfaction was directed elsewhere rather than towards the nursing staff • Participants trusted the staff judgements
O'Cathain et al (2008)	UK	Large qualitative study: n= 47 adult patients. Focus groups and interviews conducted within four weeks of using urgent care services. (Methodological weaknesses).	<ul style="list-style-type: none"> • Confusion and lack of knowledge expressed about the full range of urgent care services • Reported surprise when a quick response received from urgent care services • Reported anxiety about participant condition
Olofsson et al (2012)	Sweden	Qualitative study: n= 14 older patients. On site interviews. (Robust study).	<ul style="list-style-type: none"> • A caring relationship was reported during the triage stage of the Emergency Department experience, but the rest of the Emergency Department visit was described as a state of uncertainty and delays

			<ul style="list-style-type: none"> • Older chronically ill patients rarely given a high triage level • Spoke of waiting and feeling abandoned and neglected following triage stage • Basic needs were not met
Rhee & Bird (1996)	USA	Quantitative study: n= 618 adult patients. Telephone survey post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Technical care was perceived as more important than bedside manner
Richardson et al (2007)	New Zealand	Mixed methods study: n= 82 older patient audits, and 13 older patients interviewed on-site and 11 interviewed by telephone post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Spoke of receiving little information but were unconcerned by this, and appeared to relinquish control to the 'system' • Acceptance of processes and procedures and a general reluctance to criticise or question these
Sheppard et al (2010)	Australia	Qualitative study: n= 22 on-site interviews with adult patients and 15 follow up interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> • Reported satisfaction with the physiotherapy service provided in the Emergency Department
Spilsbury et al (1999)	UK	Qualitative study: n= 12 case studies of older patients/informal carers. On-site observations and interviews, and post discharge interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> • Spoke of busy staff • Spoke of long waiting times • Complaints of hard trolleys • Valued having a family member present
Sun et al (2000)	USA	Quantitative survey: n= 2899 adult patients completed on site questionnaire and 2333 completed a follow up telephone interview. (Robust study).	<ul style="list-style-type: none"> • High satisfaction reported with Emergency Department care • Lower satisfaction associated with occupying a low triage status, younger age and black ethnicity
Watson et al (1999)	USA	Qualitative study: n= 12 older patients. Interviewed within 72 hours of discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Waiting time was identified by all participants regardless of whether it was short or long • Spoke positively about the Emergency Department staff • Concerns raised about the Emergency Department environment and uncomfortable trolleys • Awareness of the needs of others • High levels of personal tolerance

Wiman et al (2007)	Sweden	Qualitative study: n= 23 adult trauma patients. Interviewed within nine to 35 days post injury. (Robust study).	<ul style="list-style-type: none"> Three modes of staff communication were identified. Staff changed their communication mode as the care advanced from the instrumental mode, to the attentive mode to the uncommitted mode. Satisfaction was highest for the first two modes
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Table 2: Acute Hospital Papers

Citation	Locality	Method	Findings
Arendts et al (2006)	Australia	Patient survey and computerized patient information system. n= 596 adult AMU patients. Surveyed six to eight weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Approximately 29% of patients made unscheduled visits to a medical practitioner for the same problem for which they were admitted. • 21% of patients represented at the hospital in the eight weeks post discharge, with 64% of these for the same problem for which they were admitted • Patients reported high satisfaction levels
Bruster et al (1994)	UK	Quantitative study: n= 5150 adult patients. Interviewed two to four weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Older patients reported significantly fewer problems than younger patients • One of the principle problems was communication with staff – patients were not given information about the hospital and its routine, their condition, or about tests
Charles et al (1994)	Canada	Quantitative study: n= 4599 adult medical and surgical patients. Telephone survey within three months of discharge. (Robust study).	<ul style="list-style-type: none"> • 61% reported problems with five or fewer of 39 care processes • For nearly half of the 39 care processes fewer than 10% indicated a problem • 29% indicated that that had been times when the nurses were overworked and too busy to take care of them • Older patients reported less problems than younger patients • Medical patients reported more problems than surgical patients
Cioffi (2006)	Australia	Qualitative study: n= eight medical and surgical adult patients of Asian and Middle Eastern Islamic backgrounds interviewed on site. Eight nurses interviewed. (Methodological weaknesses).	<ul style="list-style-type: none"> • Patients expected to be supported by family members who stayed at their bedside • Nurses were aware of the needs of others and consequently restricted the number of family present • Nurses were focused on instrumental activities and completed these activities in a detached manner
Danielsen et al (2007)	Norway	Quantitative study: n= 13700 adult medical and surgical patients.	<ul style="list-style-type: none"> • Age, education, health status, and gender associated with patient experience

		Questionnaires mailed to patients three weeks post discharge. (Robust study).	<ul style="list-style-type: none"> Older patients reported higher satisfaction, as did patients with less years education, higher health status and male patients
Elliott et al (2009)	USA	Quantitative study: n= 19720 adult medical and surgical patients. Postal or telephone questionnaire post discharge. (Robust study).	<ul style="list-style-type: none"> Communication with nurses was perceived as the most important domain by patients Responsiveness of staff was the second most important domain The environment (cleanliness and quietness) was the third most important domain Communication with doctors was the fourth most important domain Communication regarding medicines and discharge was the least important domain
Eriksson & Svedlund (2007)	Sweden	Qualitative study: n= six patients. Narrative interviews post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> A core story provided of 'David and Goliath'. Patients were the little person screaming for attention, fighting not only their disease but also the staff providing their care Patients felt small and powerless and had difficulty being heard
Ferguson et al (2013)	Canada	Qualitative study: n= 18 adult AMU patients. On site interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> Less than half of the patients expressed satisfaction with their AMU experience Older patients were more satisfied than younger patients Spoke of busy staff which was attributed to poor staff-patient interaction
Fosbinder (1994)	USA	Qualitative study: n= 40 adult patients and 12 acute care nurses. On-site observations and interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> The interpersonal competence of the nurse was the primary focus of the patients' comments, rather than the tasks being completed Interpersonal competence was related to : informing, explaining, instructing, teaching, getting to know the patient, humour, establishing trust and, 'going the extra mile'
Hancock et al (2003)	Australia	Quantitative study: n= 232 acutely ill older adults, 99 informal carers, and 90 nurses. On-site questionnaires. (Methodological weaknesses).	<ul style="list-style-type: none"> Comments were made on the overwhelming time constraints on nurses preventing them from providing all aspects of care Patients and carers gave similar satisfaction ratings Satisfaction was significantly higher with physical care than with psychosocial care

Hordacre et al (2005)	Australia	Quantitative study: n= 2620 adult patients. Telephone survey post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Patient satisfaction was high • Older patients reported greater satisfaction than younger patients, as did male patients, and those with less years education
Jangland et al (2009)	Sweden	Qualitative study: n= 105 adult patients. Complaints retrospectively analysed. (Robust study).	<ul style="list-style-type: none"> • Insufficient information, respect and empathy by staff were the most common complaints
Jenkinson et al (2002)	UK	Quantitative study: n= 2249 adult patients. Questionnaire one month post discharge. (Robust study).	<ul style="list-style-type: none"> • Most responders described their overall experience as good, very good or excellent • 55% of those who stated their health care was excellent also indicated four or more problems (10% of the total number of problems available) • Age was significantly associated with satisfaction (older responders were more satisfied)
Jones & Lester (1994)	UK	Quantitative study: n= 960 older patients and 865 informal carers. Postal questionnaire three months post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Respondents were positive about nursing care but more critical about the environment- 73% of patients and 81% of carers made positive comments about their hospital care • Majority of positive comments related to the caring and kindness of staff • Majority of negative comments related to social and environmental factors
Lees & Chadha (2011)	UK	Mixed methods study: n= 500 adult AMU patients. Satisfaction survey post discharge, and two patients completed retrospective diaries. (Methodological weaknesses).	<ul style="list-style-type: none"> • No quantitative results are provided • Qualitative themes from patient diaries: noisy and busy environment, waiting, inadequate communication and kind nursing staff
Mace (1998)	USA	Quantitative study: n= 28 adult AMU patients. Retrospective complaints analysed. (Methodological weaknesses).	<ul style="list-style-type: none"> • Only 28 complaints received out of a total of 11042 patients (2.5 complaints to every 1000 patient admissions) • Highest number of complaints related to staff; specifically staff attitude and behaviour

Nakano et al (2008)	Denmark	Qualitative study: n= 30 adult patients admitted to an acute cardiac care unit. On site interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> • Positive comments were made about the staff who were described as compassionate • Patients valued competent, proficient, skilful and efficient staff • Pain management was not always adequate
Parke & Chappell (2010)	Canada	Qualitative study: n= eight older patients, three informal carers and 14 hospital staff. On site observations and interviews one month post discharge. (Robust study).	<ul style="list-style-type: none"> • Highlighted that staff are in a constant rush in the acute care environment, whilst conversely patients are constantly waiting • Two groups of patients enter the acute care environment; those who fit (healthier, fewer co-morbidities, cognitively intact and those who speak English) and those who don't fit. Those patients that need more time do not fit within the system
Shatell et al (2005)	USA	Qualitative study: n= 20 adult medical and surgical patients. Post discharge interviews. (Robust study).	<ul style="list-style-type: none"> • The overarching concern was to survive • Participants minimized their negative experiences and made excuses for the staff • Valued having a family member present to reduce anxiety
Slatyer et al (2013)	Australia	Qualitative study: n= 12 older AMU patients, 15 informal carers, and 35 Healthcare professionals. Interviews within three weeks of re-presentation at the Emergency Department. (Robust study).	<ul style="list-style-type: none"> • Perceived lack of capacity in the system was associated with a focus on just the presenting complaint, rather than also on chronic health issues • Limited recall by patients and informal carers of communication with healthcare staff during the AMU admission • The busy unit was associated with constrained communication between staff and patients/informal carers
Sorlie et al (2006)	Sweden	Qualitative study: n= 10 adult AMU patients. Timeframe of interviews unknown. (Methodological weaknesses).	<ul style="list-style-type: none"> • Positive comments were made about the staff who were described as friendly, helpful and caring • Perceived staff were busy and were aware of other patients with more critical conditions • Patients felt vulnerable; were anxious about their diagnosis and felt safe on the ward
Sullivan et al (2013)	UK	Quantitative study: n= 17092 adult patients.	<ul style="list-style-type: none"> • AMU patients scored less well than the other two groups for survey

		Comparative study of 3325 AMU admissions with 3420 short stay unscheduled admissions and 10347 short stay scheduled admissions. Adult Inpatients Survey data. (Robust study).	<p>items such as pain control, privacy, involvement in decisions, and staff communication</p> <ul style="list-style-type: none"> • Only 41% of family members in the AMU group who wanted to speak to a doctor were able to do so • Only 26% in the AMU group described adequate privacy during consultations • 30% in the AMU group received conflicting information
Thi et al (2002)	France	Quantitative study: n= 533 adult medical and surgical patients. Postal questionnaire two weeks post discharge. (Robust study).	<ul style="list-style-type: none"> • Overall patients were satisfied with their experience • Older patients were more satisfied than younger patients, as were men and those with a higher general health perception on admission
Vydelingum (2000)	UK	Qualitative study: n= 10 adult patients (Hindus, Muslims and Sikhs) and six informal carers. Interviews two to three weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • The majority of patients were satisfied with their care, and numerous positive comments were made about the nursing staff • Nurses were perceived as busy
Webb (2007)	UK	Qualitative study: n= 27 adult patients, 22 family members, and 42 hospital staff. Post discharge interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> • Most patients and family members reported a reasonable overall hospital experience • Patients were acutely aware of the pressures staff worked under and made excuses for the staff • Spoke about individual staff either enhancing or breaking the experience
Williams (2004)	Australia	Qualitative study: n= 12 adult patients with comorbidities. Interviews within 14 days of discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Most patients reported satisfaction with their care • Management of the acute condition took precedence over comorbidities • Chronic conditions persisted after discharge

Table 3: Geriatrician Papers

Citation	Locality	Method	Findings
Arbaje et al (2010)	USA	Quantitative study: n= 505 older patients. Telephone interviews 14 days post discharge. (Methodological Weaknesses).	<ul style="list-style-type: none"> • The geriatric floating transition team was associated with slightly higher, but not significantly so, quality of care transition • The geriatric floating transition team was associated with slightly higher, but not significantly so, satisfaction with care
Eijken et al (2008)	The Netherlands	Feasibility study: n= two geriatricians, six nurses, 15 general practitioners, 37 informal carers, 11 older patients. General practitioner questionnaires, and interviews with all groups. (Methodological weaknesses).	<ul style="list-style-type: none"> • General Practitioners reported time limitations in the care of older people • General Practitioners reported that they were not trained to assess mobility, mood and cognition • General Practitioners, informal carers and patients appreciated the support offered by the intervention programme, although health outcomes were less reported • The intervention was assessed as feasible to implement
Limbourn & Celenza (2011)	Australia	Mixed methods study: n= 467 Emergency Department adult patients. On site questionnaire. (Methodological weaknesses).	<ul style="list-style-type: none"> • 93.3% stated their assessment and treatment was good to excellent • Free text responses revealed attributes most liked regarding Emergency Department doctors: friendly, polite, attentive, caring, concerned, efficient, competent, and thorough • Free text responses revealed attributes least liked regarding Emergency Department doctors: hurried, distracted and poor communication skills

Table 4: Discharge Papers

Citation	Locality	Method	Findings
Bobay et al (2010)	USA	Quantitative study: n= 1892 adult medical and surgical patients. On-site questionnaire. (Methodological weaknesses).	<ul style="list-style-type: none"> Older patients were more likely to have experienced a prior hospitalisation for the same condition than younger older patients, and to have been hospitalised within the past three months Older patients perceived they received less information about discharge than the younger patients
Bruster et al (1994)	UK	Quantitative study: n= 5150 adult patients. Interviewed two to four weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> Patients gave highly positive results to satisfaction questions (89%) despite highlighting problems via the more direct questions Older patients reported significantly fewer problems than younger patients, as did men, patients of white ethnicity and those with planned admissions At discharge patients reported that they were rarely given information about how they could continue with their lives, or how they could help their recovery
Bull et al (2000)	USA	Quantitative study: n= 134 older patients (hospitalised with heart failure) alongside their informal carer. Interviewed two weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> Patients and informal carers reported high levels of satisfaction with discharge Longer term carers and those in poorer health were more likely to report lower levels of satisfaction with discharge planning
Clarke et al (2010)	UK	Qualitative study: n= 23 adult patients (hospitalised with chronic obstructive pulmonary disease). 14 patients who accepted the early supported discharge service, and nine patients who declined the service interviewed post	<ul style="list-style-type: none"> Patients in both groups reported being discharged too soon Patients were reluctant to negotiate increased time in hospital despite their concerns about not being ready to return home Patients spoke of difficulty being at home after the acute admission

		discharge. (Robust study).	
Foust et al (2012)	USA	Qualitative study: n= 40 adult home care patients, 35 informal carers, and 15 home care clinicians. Post discharge interviews. (Robust study).	<ul style="list-style-type: none"> • 75% of patients learnt of discharge at least one day beforehand. However the informal carers did not share this experience • The informal carers described a peripheral status in the discharge process • The informal carers experienced frustration with accessing information from hospital staff, with the hospital discharge process described as patient rather than family centred
Grimmer et al (2000)	Australia	Quantitative study: n= 1126 informal carers of older patients discharged from acute medical and surgical wards. Post discharge postal questionnaire. (Methodological weaknesses).	<ul style="list-style-type: none"> • 28% of carers reported having significant health problems, with the highest percentage reported by carers aged 65 years and older • Carers mental quality of life scores were significantly below the population norms • Carers rated the quality of discharge planning significantly lower than did the patients • Free text responses were predominantly negative, and were largely around inadequate communication
Hesselink et al (2012)	5 European countries: The Netherlands, Spain, Poland, Italy and Sweden	Qualitative study: n= 348 participants, composed of: 90 adult patients/or informal carers, 76 hospital physicians, 70 hospital nurses, 70 general practitioners, and 42 community nurses. Individual interviews (n= 192) or focus groups (n= 26) three to four weeks post discharge. (Robust study).	<ul style="list-style-type: none"> • Healthcare professionals did not sufficiently prioritise discharge consultations with patients and informal carers due to time constraints and competing care obligations • Discharge consultations often took place at a time convenient to physicians which often meant informal carers were not present • Patients mentioned instances of sudden and abrupt discharges • Bed shortages often resulted in premature discharges
Huby et al (2007)	UK	Qualitative study: On-site interviews with 22 older patients and 11 healthcare professionals. Follow-up interviews with 11 older patients.	<ul style="list-style-type: none"> • Many patients spoke about lacking the language, skills and vocabulary to speak with 'educated' health care staff about discharge

		(Methodological weaknesses).	<ul style="list-style-type: none"> Patients appeared passive with regards to engaging in the discharge process
Jewell (1993)	UK	Qualitative study: n= four older patients, two informal carers, and 26 healthcare professionals. Interviews 10-14 days post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> Discharge was reported as a team decision, however patients were often not part of this team, unless they were vocal and articulate Patients reported ignorance and uncertainty in respect of decision making at discharge Patients experienced problems post discharge, such as understanding medication and managing their ADLs
Jones & Lester (1994)	UK	Quantitative study: n= 960 older people and 865 informal carers. Postal questionnaire three months post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> High satisfaction expressed with the discharge process Informal carers were more likely than patients to be dissatisfied with the discharge process, particularly in respect of length of notice, and more likely to think patients had been discharged prematurely 56% of informal carers who thought discharge had been premature felt they were not sufficiently involved in the discharge process
Knight et al (2011)	UK	Qualitative study: n= seven older people and 12 informal carers. Interviewed within one month post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> Overall participants were not satisfied with the discharge process Spoke of the discharge process as an anxious time when they were uncertain when they would be going home Spoke of delays in respect of waiting to obtain discharge medication Staff were perceived as busy and to have insufficient time to give information
Lotus Shyu (2000)	Taiwan	Qualitative study: n= 16 informal carers of older patients. Interviewed prior to discharge, two weeks post discharge, and one month post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> Informal carers went through three phases of the caregiving role: role engaging (before discharge), role negotiating (after discharge) and role settling (after role negotiation)

Pearson et al (2004)	UK	Qualitative study: n= 30 adult medical patients, 121 hospital and community healthcare professionals, and informal carers (number not provided). Pre and post discharge interviews. (Methodological weaknesses).	<ul style="list-style-type: none"> • Informal carers reported that they felt taken for granted by hospital staff • Informal carers spoke of anxiety and the need to juggle their needs, their family needs and the patient's needs
Procter et al (2001)	UK	Qualitative study: n= 30 adult medical patients and 11 informal carers. Interviewed in hospital & two weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Spoke of an assumption that the informal carer could cope on discharge • Informal carer needs not recognised by healthcare professionals
Richardson et al (2007)	New Zealand	Mixed methods study: n = 82 older patient audits, and 13 older patients interviewed on site and 11 interviewed by telephone post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Patients adopted a passive role • There was little evidence to suggest that patients were consulted or involved in their discharge
Roberts (2002)	UK	Mixed methods study: n= 518 older people completed questionnaires and 30 older people interviewed. (Methodological weaknesses).	<ul style="list-style-type: none"> • Most felt they had been spoken to about the discharge process • Many were content to let the healthcare professionals make decisions on their behalf, stating that the professionals 'know best' and 'are the experts' • All waited for 'permission' to go home
Slatyer et al (2013)	Australia	Qualitative study: n= 12 older AMU patients, 15 informal carers and 35 healthcare professionals. Interviewed within three weeks of re-presentation at the Emergency Department. (Robust study).	<ul style="list-style-type: none"> • Re-presentation at the Emergency Department occurred as a result of symptom recurrence, functional decline or due to the substantial informal carer involvement • Healthcare professionals described these patients as 'borderline' when being discharged, i.e. they met the minimum criteria for discharge in the context of a high demand for AMU beds

Table 5: ADL Papers

Citation	Locality	Method	Findings
Clark et al (1997)	Australia	Quantitative study: n= 71 older patients and 52 informal carers. Interviewed prior to discharge and seven to 10 days post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • 86% of respondents reported they were usually independent with their physical ADLs, but only 72% reported independence on discharge • 44% of respondents reported they were usually independent with their domestic ADLs, but only 25% reported independence on discharge • 60% of respondents required assistance with shopping, 55% with meal preparation, and 68% with housework on discharge • At follow up the number of patients requiring assistance with domestic ADLs had increased
Coffey & McCarthy (2013)	UK	Quantitative study: n= 335 older patients. Measurements taken at discharge and six weeks post discharge via a telephone survey. (Methodological weaknesses).	<ul style="list-style-type: none"> • On discharge 20% of respondents reported receiving help with personal ADLs from informal carers, and 69.2% with domestic ADLs • At six weeks post discharge there had been a 9% increase in the number of respondents receiving help with personal ADLs, and a 10% increase in those requiring support with domestic ADLs • The amount of formal support increased minimally with an increase of just 0.5% receiving home care
Corser et al (2006)	USA	Qualitative study: n= 165 older veterans. Telephone interviews post discharge (average 33 days post discharge). (Methodological weaknesses).	<ul style="list-style-type: none"> • 18 respondents spoke of changes to either their functional abilities or physical status • 21 respondents spoke of changes to their social functioning

Dyas & Thom (2002)	UK	Qualitative study: n= 20 older patients. Interviewed six weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Participants spoke of mobility and psychological issues, such as loss of confidence and fear, impairing their ability to return to 'normal functioning' • Participants wished to 'get back to normal' post discharge • Participants identified the need for reassurance and confidence building services post discharge
Eriksson et al (2009)	Sweden	Qualitative study: n= 15 adult acute myocardial infarction patients and their informal carer. Interviewed four to eight weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Some patients reported limitations in physical functioning on discharge • Some patients took everyday activities easier and did not over exert themselves • Patients described their efforts to return to normal everyday life
Farnsworth et al (1995)	UK	Quantitative study: n = 23 older Emergency Department patients. Post discharge interviews (10-20 days). (Methodological weaknesses).	<ul style="list-style-type: none"> • 6 (26%) of respondents reported specific worries about their ability to cope on discharge • 9 (39%) of respondents required additional support post discharge , five were supported by their family, two by neighbours, one by home care and one by care home staff
Fitzgerald Miller et al (2008)	USA	Mixed method study: n= 113 adult medical and surgical patients. Telephone interview three weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • 11 (10%) of respondents reported mobility issues related to inability to climb the stairs, being home bound and getting in and out of bed • Nine (8%) of respondents reported difficulty taking a shower • 21 (19%) of respondents reported concern that their family needed to take on additional ADLs
Gage et al (1997)	Canada	Qualitative study: n = 24 adult patients. Focus groups (n= 13) and	<ul style="list-style-type: none"> • Participants spoke of internal resources rather than support of healthcare

		individual telephone interviews (n= 11) at least three months post discharge. (Methodological weaknesses).	<p>professionals when it came to managing at home</p> <ul style="list-style-type: none"> • Participants spoke of managing at home due to help provided by informal carers • The availability of rehabilitation services post discharge was perceived as enabling continued progress towards independence • Positive comments were made valuing the provision of assistive equipment (walkers, raised toilet seats, grab rails, bath aids) in aiding the transition home
LeClerc et al (2002)	Canada	Qualitative study: n= 14 older women. Interviewed six to eight weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • Acute hospital discharge plans focus on just meeting the basic physical and medically related needs of older women • Participants spoke of the struggle to complete their basic personal ADLs & domestic ADLs post discharge • Participants spoke of needing to rely on informal carers to meet their ADL needs, a concern about being a burden on their informal carers, and a desire to maintain a strong and independent self-identity • The recovery process was described as 'isolating' from the outside world, and the women limited their social and spiritual activities
Mamon et al (1992)	USA	Quantitative study: n= 919 older medical and surgical patients. Telephone interviews two to four weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • One third of respondents reported an unmet home care need • 11% of respondents reported an unmet ADL need/s • 76% of respondents reported one or more ADL needs

			<ul style="list-style-type: none"> • 62% of respondents reported new ADLs needs since admission
McKeown (2007)	UK	Qualitative study: n= 11 older patients discharged from acute hospital wards. Interviewed two weeks post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • 10 participants reported difficulty with bathing • Eight participants reported difficulty completing their domestic ADLs • Participants spoke about receiving significant support from informal carers • Six participants spoke of unmet needs in respect of aids and environmental modifications • Those participants that lived alone spoke of being lonely
Mistiaen et al (1997)	The Netherlands	Quantitative study: n= 145 older patients discharged from acute wards. Questionnaires or interviews one week post discharge. (Methodological weaknesses).	<ul style="list-style-type: none"> • 53% respondents reported difficulty completing their personal ADLs • 77% respondents reported difficulty completing their domestic ADLs • 74% respondents reported difficulty with their functional mobility • 37% respondents reported one or more unmet needs • Respondents reported that help was largely provided by informal carers
Small & Graydon (1993)	Canada	Qualitative study: n= 25 adult patients with chronic obstructive pulmonary disease. On-site interviews across five large acute care hospitals. (Methodological weaknesses).	<ul style="list-style-type: none"> • 15 participants reported concerns about managing their personal and domestic ADLs on discharge • Nine participants were concerned whether they would return to their previous level of functioning and thought they would need assistance on discharge

Note: The Health Care Practice Research and Development Unit tool (Long et al 2002) was independently applied to all the studies outlined in Tables 1-5. The tool was used as a means of ensuring that the critique was completed systematically and consistently in an effort to reduce as far as possible the influence of personal bias. Each study was judged as either rigorous or methodologically weak. This judgement was made in accordance with the ontological position and design of the study. For example, strategies to enhance rigour, such as member checking and use of multiple researchers to code and discuss interpretations, were necessary criteria to be fulfilled

in critical realist studies. However these same strategies were considered irrelevant in relativist studies, where the presence of reflexivity was judged as necessary to demonstrate rigour. Likewise the sample size was judged as sufficient or insufficient according to the overall design of the study. Large sample sizes were necessary to meet the criteria for quantitative studies, whereas small purposive or theoretical samples were necessary to meet the criteria for qualitative studies.

It is recognised that some of the papers evaluated as weak may have been rigorous, but poorly described due to the word limitations imposed by journals.

Appendix 2 (a)

Participant Interview Guides

Post-discharge Interview Guide for Patient Participants

I would like to find out about what you thought about your recent hospital admission. I would like to tape record the interview, so that I can concentrate on what you are saying, would that be ok? The interview is very informal, I really just want to have a chat, and find out your experience related to your recent hospital admission.

The interview will be confidential and you can say what you like. Hopefully it will help us design better care in the future.

- 1) Complete consent forms**
- 2) Turn on digital recorder.**

Rapport questions:

Can we start by you telling me a little about yourself?

- Do you live alone or with someone?
- Do you have any family living near-by? How often do you see your family?
- Do you have any friends who live near-by? Do you manage to see them?
- Before your hospital admission did anyone come in to help you with everyday tasks? Tell me about that.

Before the admission:

Thinking back can you tell me what happened on the day you went into hospital? Tell me what happened from the start.

Prompts to encourage narratives:

- Talk me through how you were feeling and managing before you went to the emergency department, or your doctor. What was happening?
- What events led to you being admitted to the ward?

Prompts to encourage views:

- Tell me what it was like coming into hospital?

During the admission:

Can you talk me through your memories of what happened to you on the ward?

Prompts to encourage narratives:

- Have you got anything that stands out as particularly memorable during your stay?
- Tell me about the treatment you received on the ward.
- Tell me about the care you received on the ward.
- What did the nurses say and do to you?
- What did the doctors say and do to you?

- Can you recall being seen by the specialist doctor, for people aged over 70 years, on the day you left the ward? Tell me what happened?

Prompts to encourage views:

- How happy were you with the care and treatment received?
- Did you have any expectations around your care and treatment? Were they met?

Discharge:

Can you tell me how you found out that you were going home?

Prompts to encourage narratives:

- I suppose that various arrangements were put into place, can you recall what happened around this time?

Prompts to encourage views:

- Looking back at the time of the discharge, what impression do you have of it?
- How could the discharge have been any better?

Returning home:

Finally, tell me how you have been getting along since you came home from hospital.

Prompts to encourage narratives:

- Talk me through the day you came home.
- What has it been like since you got home?
- How have you been managing on a day to day basis?
- Have you been able to do what you used to do? (if any difficulties mentioned by participant) -Tell me about that?
- Have you seen the specialist doctor for older people since returning home? Tell me about that.

Prompts to encourage views:

- Do you think the care and treatment received from the hospital has made your life any easier, or is it the same, or more difficult since returning home? Have you got any examples?
- Can you suggest any improvements or better ways of doing things on the ward?

Thank you for your help. I really appreciate it. It will help the Trust to understand what people think.

Post-discharge Interview Guide for Carer Participants

I would like to find out what you thought about your recent contact with the hospital relating to <insert name of patient participant>attendance. I would like to tape record the interview so that I can concentrate on what you are saying, would that be ok? The interview is very informal, I really just want to chat, and find out your experience related to <insert name of patient participant>recent hospital admission.

The interview will be confidential and you can say what you like. Hopefully it will help us design better care in the future.

- 1) Complete consent forms**
- 2) Turn on digital recorder.**

Rapport questions:

Can we start by you telling me a little about yourself?

- Do you live with ----- (the person you care for)?
- Tell me about the support you provided for ----- (the person you care for) before the hospital admission.
- Did you have any family, friends, neighbours or services who helped with the care of ----- (the person you care for) before the hospital admission? Tell me about that.
- Did you go out to work or have other commitments before the hospital admission?

Before the admission:

Thinking back can you tell me what happened before ----- (the person you care for) went into hospital?

Prompts to encourage narratives:

- How did ----- (the person you care for) end up being admitted to the ward?

Prompts to encourage views:

- Before coming into hospital how was ----- (the person you care for) on a day to day basis?
- Before coming into hospital how was ----- (the person you care for) getting along at home?

During the admission:

What I would like you to do is to tell me what happened on the day ----- (the person you care for) went to the hospital. Tell me what happened from the start.

Prompts to encourage narratives:

- Tell me about the treatment ----- (the person you care for) received on the ward.
- Tell me about the care you saw ----- (the person you care for) receiving on the ward.

- Have you got anything that stands out as particularly memorable about their stay on the ward?
- Can you recall -----(the person you care for) being seen by the specialist doctor, for people aged over 70 years, on the day they left the ward? Tell me what happened?

Prompts to encourage views:

- What struck you about their treatment and care on the ward?
- How happy were you with the care and treatment received on the ward?
- Did you have any expectations around the care and treatment? Were these expectations met?
- How well do you think the hospital stay helped -----(the person you care for) or you?

Discharge:

Can you tell me how you found out that ----- (the person you care for) was going home?

Prompts to encourage narratives:

- I suppose that various arrangements were put into place, can you recall what happened around this time?

Prompts to encourage views:

- Looking back at the time of the discharge, what impression do you have of it?
- How could the discharge have been any better?

Returning home:

Finally, can you talk through how things have been since -----(the person you care for) returned home?

Prompts to encourage narratives:

- What has it been like since they got home?
- Have they been able to do what they used to do?
- (if any difficulties mentioned by participant) -Tell me about that?
- Have you been able to do what you used to be able to do?
- (if any difficulties mentioned by participant)-Tell me about that?
- Have they seen the doctor who specialises in older people since returning home? Tell me about that.

Prompts to encourage views:

- Do you think the care and treatment received from the hospital has made their life or your life any easier, or is it the same, or more difficult since returning home?
- Can you suggest any improvements or better ways of doing things on the ward?

Appendix 2 (b)

Participant Information Sheets

Patient Participant Information Sheet for the interview study

We would like to invite you to take part in an interview study. Before you decide you need to understand why the research is being done and what it would involve. Please take time to read the following information carefully. Take time to decide whether or not to take part. Ask questions when the researcher visits you if there is anything which is unclear or if you would like more information.

We are looking to interview a small group of people who are taking part in the (East Midlands RCT). The interview is being completed to obtain your views on the hospital stay and how you have felt since you left the hospital.

What is the purpose of the study?

The interview study is being completed alongside the (East Midlands RCT) to obtain patient and carer views on the care and treatment received during the hospital stay, and to find out how you have felt since leaving the hospital.

Why have I been invited?

People who indicated an interest in the interview study when recruited to the (East Midlands RCT) are being approached. We are looking to recruit up to 15 patients to take part in the interviews.

Do I have to take part?

No. Taking part in the interview study is entirely voluntary. Not taking part will not affect the care you receive. It's up to you to decide. The researcher will describe the study and go through this information sheet with you at the time of the interview. We will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

We will interview you in a place of your choice, perhaps your home, at a time that is convenient to you. The interview will last for approximately an hour and with your permission will be recorded. This will enable the researcher to concentrate upon your comments rather than taking notes. The researcher will ask about:

- What led to the hospital admission
- Your hospital stay
- The care and treatment received
- What helped or did not help
- The discharge home
- Returning home

All the information provided in the interview is confidential and although direct quotes from the interview may be used in study reports these will be anonymised.

What are the possible disadvantages and risks of taking part?

There are no anticipated risks. The study will require approximately an hour of your time and you can decide what information you wish to provide. If you change your mind about something you say you can ask the researcher not to use the information.

What are the possible benefits of taking part?

You may not benefit personally by taking part in this study although you may find the opportunity to talk about your experiences to be of benefit. The information provided may help to improve the care and treatment of people like you in the future.

What if there is a problem?

If you have a concern about any aspect of this study you can ask to speak to the (RCT) researchers who will try to do their best to answer your questions (Ms Janet Darby tel no: -----, Dr ----- tel no: ----- or Professor ----- tel no -----). If you remain unhappy and wish to complain formally you can do this through the NHS complaints procedure. Details can be obtained from the hospital.

In the event of any harm occurring as a result of the research there are no special compensation arrangements. If you are harmed by someone's negligence, then you may have grounds for legal action but you may have to pay your legal costs.

Will my taking part in this study be kept confidential?

Yes. All information collected during the course of the study will be kept strictly confidential. However if the researcher comes across any important clinical matters they will report them to the GP with your permission.

Confidentiality will be safeguarded in all reports. Your name and any personal details will be removed from any information so that you cannot be recognised from it. Information and interview tapes will be retained for three years and then disposed of securely.

What will happen if I don't want to carry on with the study?

If you withdraw from the study we will need to keep and use the data collected.

What will happen to the results of the research study?

These will be presented at medical meetings and published in medical journals. You will not be identified in any report or publication.

Who is organising or sponsoring the research?

The (sponsor) is organising the study which is funded by a research grant provided by the National Institute of Health Research.

Who do I contact for further information?

If you wish to have further information please contact:

Janet Darby, Research Associate. Address---. Telephone no: -----

Thank you for reading this information

Carer Participant Information Sheet

We would like to invite you to take part in an interview study. Before you decide you need to understand why the research is being done and what it would involve. Please take time to read the following information carefully. Take time to decide whether or not to take part. Ask questions when the researcher visits you if there is anything which is unclear or if you would like more information.

We are looking to interview a small group of people who are taking part in the (East Midlands RCT). The interview is being completed to obtain your views on the hospital stay which the person you care for recently experienced, and to find out how you have felt since this person left the hospital.

What is the purpose of the study?

The interview study is being completed alongside the (East Midlands RCT) to obtain patient and carer views on the care and treatment received during the hospital stay, and to find out how patients and carers have felt following the hospital stay.

Why have I been invited?

Carers who indicated an interest in the interview study when recruited to the (East Midlands RCT) are being approached. We are looking to recruit up to 15 carers to take part in the interviews.

Do I have to take part?

No. Taking part in the interview study is entirely voluntary. If you do not wish to take part, it will not affect the care the person that you care for receives. It's up to you to decide. The researcher will describe the study and go through this information sheet with you at the time of the interview. We will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

We will interview you in a place of your choice, perhaps your home, at a time that is convenient to you. The interview will last for approximately an hour and with your permission will be recorded. This will enable the researcher to concentrate upon your comments rather than taking notes. The researcher will ask about:

- What you think led to the person you care for going into hospital
- Your views about the hospital stay
- Your views on the care and treatment received
- Your views on what helped or did not help
- Your views on the discharge
- Your views on the return home

All the information provided in the interview is confidential and although direct quotes from the interview may be used in study reports these will be anonymised.

What are the possible disadvantages and risks of taking part?

There are no anticipated risks. The study will require approximately an hour of your time and you can decide what information you wish to provide. If you change your mind about something you say you can ask the researcher not to use the information.

What are the possible benefits of taking part?

You may not benefit personally by taking part in this study although you may find the opportunity to talk about your experiences to be of benefit. The information provided may help us to design better services.

What if there is a problem?

If you have a concern about any aspect of this study you can ask to speak to the (RCT) researchers who will try to do their best to answer your questions (Ms Janet Darby tel no: ----, Dr -----, tel no: -----, or Professor -----, tel no: -----). If you remain unhappy and wish to complain formally you can do this through the NHS complaints procedure. Details can be obtained from the hospital.

In the event of any harm occurring as a result of the research there are no special compensation arrangements. If you are harmed by someone's negligence, then you may have grounds for legal action but you may have to pay your legal costs.

Will my taking part in this study be kept confidential?

Yes. All information collected during the course of the study will be kept strictly confidential. However if the researcher comes across any important clinical matters they will report them to whoever needs to know with your permission.

Confidentiality will be safeguarded in all reports. Your name and any personal details will be removed from any information so that you cannot be recognised from it. Information and interview tapes will be retained for three years and then disposed of securely.

What will happen if I don't want to carry on with the study?

If you withdraw from the study we will need to keep and use the data collected.

What will happen to the results of the research study?

These will be presented at medical meetings and published in medical journals. You will not be identified in any report or publication.

Who is organising or sponsoring the research?

The (sponsor) is organising the study which is funded by a research grant provided by the National Institute of Health Research.

Who do I contact for further information?

If you wish to have further information please contact;

Janet Darby, Research Associate. Address-----. Telephone no: -----

Thank you for reading this information

Appendix 2 (c)

Participant Consent Forms

Post Discharge Interview Study Patient

Patient Participant Consent form

Participant identification number for this study: _____

Name of Researcher: _____ Please initial box

1. I confirm that I have read and understood the information sheet for the above study (version 1, 08/11/2010). I have had the opportunity to consider the information, ask questions and had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am under no obligation to participate. I understand that I can withdraw from the study at any point without providing a reason, and without my medical care or legal rights being affected. I understand that if I do withdraw the information collected up until this point may still be used in the study. ☐

3. I agree to the interview to being recorded, and for anonymised direct quotations from the interview may be used in publications, the final report and any presentation of findings. ☐

4. I agree to take part in the study. ☐

5. I agree to my carer taking part in an interview study about their views on my hospital stay, discharge and resettlement at home. ☐

6. I agree to my GP being informed of my participation in the study. ☐

	//	
Name of person	Date	Signature
	//	
Name of person taking consent	Date	Signature

When completed: 1 for patient; 1 (original) for researcher; 1 for medical notes

Post Discharge Interview Study

Carer Participant Consent Form

Patient identification number for this study: _____

Name of researcher: _____

Please initial box

1. I confirm that I have read and understood the information sheet for the above study (version 1, 08/11/ 2010). I have had the opportunity to consider the information, ask questions and had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am under no obligation to participate. I understand that I can withdraw from the study at any point without providing a reason, and without my medical care or legal rights being affected. I understand that if I do withdraw the information collected up until this point may still be used in the study.

3. I agree to the interview to be recorded, and that anonymised direct quotations from the interview may be used in publications, the final report and any presentation of findings.

4. I agree to take part in the above study.

Name of carer

____/____/____
Date

Relationship to participant

Signature

Name of person
taking consent

____/____/____
Date

Signature

When completed: 1 for carer; 1 (original) for researcher site file

Appendix 2 (d)

Thematic Analysis Codes

Uncertainty/anxiety about cause of illness	Forgetful
Personality; take things as they come	Unanswered questions
Selfless; put others first	Monitoring
Recent/repeat admissions	No complaints
Just waiting in bed	Staff checking regularly
Pleased staff provided toiletries	External factors
Personality; enjoys people watching	No or little treatment
Quick follow up	Just in over night
Exceeded expectations	Nurses/doctors were good
Happy/pleased/satisfied	A drama
Stuck/captured on ward	Good re: bed beside nurses station
Pre-prepared hospital bag	No change as result of AMU
Personality; don't class self as old	Positive about environment
Not in long enough to make comments	Food/drinks provided
Quite pleased/happy/content	Awareness others may moan
Staff provided information/explanation	Felt alright/ok/not unwell
Staff were kind/caring	Disturbed by another patient
Lack of privacy	Night disturbance
Upset/frightened/anxious	Lack of dignity
Could be better	Lack of apology/reassurance
Comparison to TV programme	Delayed tests/treatment
Negative re: bed beside nurses station	Not grumbling
Negative compared to previous experience	Not blaming the staff
Neutral language re: care/treatment	Staff not visible
Long wait for food	Had to fetch own food
Carer difficulty contacting ward	Noise disturbance
Tried to help other patients	Staff are busy
Staff amenable to other appointments	Lack of explanation/communication
Excuses made for staff	Wanted to go home

Negative /unhappy about ward	Did not meet expectations
No one wants to go or stay in hospital	Realistic/pragmatic
Would not return to ward	Awareness of nature of ward
Disturbed by staff activity	Unfamiliar experience
Traumatic/emotional experience	Felt unsafe/safe
Felt lucky/unlucky	Positive re: food
Explained reason for not complaining	Waiting
Surprised went home	Toileting needs met
Conflicting advice/intervention	Sudden move to discharge
Planned tests/intervention not completed	Mediocre/indifferent comment
Always been treated well in hospital	Positive re: GP
Personality: not a moaner/complainer	Recognition re: ageing
Discussion took place amongst doctors	Awareness of needs of others
No means of summoning help	Need to fit around staff
Left waiting; nobody bothered	Felt better by time arrived on ward
Let down by GP	Professional voice of authority
Felt sorry for the staff	Treated on ward
Positive comparison to previous experience	Staff apology
Outcome of care/treatment- better	Praised staff
Good care whilst waiting for AMU bed	Fear/dislike of hospitals
More staff needed	Did not want to trouble others
Patients come first	Accepting of situation
Familiarisation with hospitals	Hospitals are a necessity
Grateful for care/treatment	Best to be on the safe side
Personality; a fighter	Care not needed
Anxiety re: repeat admissions	Staff have a lot to cope with
Patients supported each other	Public/media perception
Care related to practical tasks	Pressure on doctors
Limited previous hospital experience	Only so much staff can do
Patient/carers proactive	Too much paperwork
Difficulty understanding foreign staff	Quick admission to ward
The only complaint...	Nothing to do

Soften the criticism	Staff not bothered
Telling the truth	Personal care needs met
Wish to thank staff	Shortage of beds
Not anxious/worried	Compliment made
Patients awkward so affect staff behaviour	Before NHS
Patients grumbling about other patients	Dislike food
Not criticizing/complaining	Resignation/acceptance
Repetitive questioning	Dislike bedpans
Good night sleep	Interested in hospitals
Not assisted with personal care	Positive re: single sex bays
Expectation	Not prepared for admission
Anxiety re: future care/health	Young staff
Pre-occupied with symptoms	Less well since AMU admission
Pain	Not given medication
Discomfort	Preference for own room
Staff short with patients	Waited for tablets
Discharge was ok	Practical difficulty collecting patient
Difficulty contacting ward	Uncertainty re: discharge time
GP did not follow hospital advice	Waiting around for discharge
Frustration re: discharge	Did as told by staff
Low expectations	Need to be kept informed
Uncertainty re: giving advice to professionals	No discussion re: discharge
On-going health concerns post discharge	Discharge was quick
Medication issues post discharge	Sorted out own transport home
Poor communication between ward & primary care	
Problems with hospital transport	Lack of follow up support
Late discharge	Conflicting advice
Lack of consideration for carer	Discharged too soon
Well planned discharge	Needed to see GP post discharge
Poor discharge	Indecision re: discharge
Staff did everything needed	Recollection of discharge vague
Staff provided information re: discharge	No wait for medication

Geriatrician was nice/good	Poor memory of information
Geriatrician completed examination	Geriatrician advised on medication
Multiple doctors/multiple appointments	Quick geriatrician follow up
Uncertainty re: who arranged tests	Difficulty getting to follow up tests
Geriatrician intervened where GP had failed	Geriatrician just spoke to them
Positive re: geriatrician follow up tests	Geriatrician listened
Provided contact/no contact number	Better as result of geriatrician
Geriatrician tried to arrange home care	Appreciation for home visit
No need for geriatrician involvement	No recall of geriatrician
Geriatrician did nothing	Geriatrician liaised with doctor
Geriatrician wrote to patient	Geriatrician busy
No follow up geriatrician visit	Health interfering with activities
Likes to help other people	Loss of confidence in ADLs
Loss of confidence to go out the home	Happy with ADLs
Loss of confidence to go to social activities	Family presence
Desire to do ADLs	Difficulty with bath transfers
Embarrassment/reluctance to be perceived as old/ill/disabled	
Completing ADLs as a distraction	Illness impacting on carers work
Family take turns to offer support	Over protective family
Difficulty completing personal care	Problems ascending stairs
Stoical attitude	Increased ADLs since discharge
Value of occupation	Desire to be independent/well
Reluctance to accept help	Illness impacting on carer
Demands on carer	Home care seen as intrusion
Appreciation for OT input	Increased dependence
Help needed with domestic activities	Anxiety re: falls
Alone/isolated	Work with family as a team
Difficulty completing valued activities	House proud
Outstanding OT needs	Reduced mobility
Support of good neighbours	Long wait in ED
Lack of privacy in ED	Holding bay
Treated well by paramedics	Uncomfortable stretcher

Long wait for AMU bed

Called ambulance as knew was very ill

ED admission delayed by ambulance

Busy in ED

Ambulance was quick

Toileting needs not met in ED

Cold in ED

Left alone in ED

Positive regarding ED

Unhappy/negative re: ED

No food/drink in ED

Singled out one nurse for praise

Appendix 2 (e)

Thematic Analysis Codes ► Thematic Analysis Sub-theme

Thematic analysis codes:

- Shortage of beds
- Not blaming the staff
- Patients awkward so affects staff behaviour
- External factors
- More staff needed
- Staff are busy
- Excuses made for staff
- Felt sorry for the staff
- Staff have a lot to cope with
- Patients come first
- Excuses made for staff



Thematic analysis sub: theme: Dispersal of blame

Appendix 2 (f)

Example of a fully formed narrative

I was disappointed

Orientation:

... because I sat there [indicating armchair], the first one [seizure], I sat there, so I say we were going to a 60th Birthday party, and er, it was a friend, she's, they've moved, they used to live across the road, but we've been, well we worked together we've been friends for years but she passed away two years ago, she did, and we was friends. I couldn't have asked for a better friend, and she'd told her daughter, let's go over, they've always, everybody calls me Ann, "come on we'll going to Ann's", and that, and er, so I say her husband was 60, and he said "I'm going to have a party Ann, are you coming to my party?" So I said "yer I'll come to your party",

Complicating Action:

And then I say this happened [seizure] [change in intonation of voice],

Resolution:

had to ring up and say "Ann's not be coming she's in the hospital".

Evaluation:

So that was a bit disappointing (Annie pg 4).

The above narrative shows the four core components of the model as applied to a single narrative.

Appendix 2 (g)

Meaning ascribed to a fully formed narrative

The narrative in appendix 2 (f) was analysed as follows:

The meaning of the narrative:

The participant was planning to attend a party with some old friends, whom she was close to, but her seizure prevented her from attending, and this left her feeling disappointed. The participant provides an example of how her seizures have interfered with something she values. The narrative highlights how an unresolved health issue is impacting on valued activities.

Appendix 2 (h)

Data Display Table Format

The data display table below is provided as a template of the format used.

Title of Data Display Table: E.g. Difficulty completing ADLs

Participant ID	Attribute of interest E.g. <i>ADL difficulty</i>	Decision rule: This states the boundaries of the data which are to be included in the table. The decision rule ensures consistency by establishing clear criteria. E.g. the rule might stipulate that all quotations in relation to ADL difficulty are included in the analysis.
Annie	+	Legend: This stipulates the strength of response made by participants. A key is provided. E.g. + Difficulty completing ADL but can complete independently ++ Difficulty completing ADL; needs help +++ Unable to complete ADL; completed by another (The highest grade across personal & domestic ADLs is assigned) A key to abbreviations is also provided. E.g. NC = No comment made in relation to attribute
Leonard	+++	
Grace	+++	
Beryl	+++	
Charles	+++	
Kath	+++	
Albert	++	
David	++	
Ida	+++	
Doris	+++	
Norman	+++	
Barry	+++	
Malcolm	+++	
Norma	+++	
Edna	+++	
Freda	NC	
Jean	+++	
Jake	NC	

Each data display table is accompanied by a narrative. E.g. all but one of the participants spoke of difficulty completing their personal ADLs and /or their domestic ADLs. The majority of participants were reliant on others to complete the activities for them.

Appendix 3 (a)

Shortfalls in Satisfaction Theme

Data Display Table

Participant ID	Strength of Response
Annie	+ ED +
Leonard	+++
Grace	+
Beryl	+ ED +++
Clare (carer)	++ ED +++
Charles	+++
Betty (carer)	+++
Kath	+++ED ++
Jane (carer)	+++ED +
Albert	++ED ++
David	+
Ida	++ED +
Doris	+
Norman	++
Barry	+ED +
Malcolm	NC
Norma	+ED +
Edna	++
Freda	++
Keith (carer)	++
Jean	+
Diane (carer)	++
Jake	NC
Vera (carer)	++ ED ++

Decision rule: Every quotation read in relation to dissatisfaction & rated according to strength.

Legend: Strength of response:

+ Participant voiced a minor fault

++ Participant expressed being dissatisfied/upset/unhappy with experience. Tests/treatment not completed.

+++ Participant voiced strong displeasure/Made complaint/voiced awful or nightmare experience

(Attributes are graded. The highest strength is recorded for each participant on the table)

ED= Emergency department

Summary: All but two of the patient participants expressed weaknesses or flaws with their care and treatment. The two outliers (Jake & Malcolm) were muddled about their admission and were unable to recall clear details of their stay on the AMU. Three patient participants, and two of their carers, voiced strong dissatisfaction about the AMU experience. Seven of the patient participants and three of the carer participants expressed negative comments about the emergency department, and as this preceded the AMU stay, may have impacted on their overall perception of the experience (i.e. all participants expressing a negative perception of the emergency department also expressed negative perceptions of the AMU).

Appendix 3 (b)

Shortfalls in Satisfaction Sub-themes

Data Display Table

ID	Sub theme (a): Perceived lack of treatment	Sub theme (b): Constant disturbance	Sub theme (c): Waiting	Sub theme (d): Inadequate communication	Sub theme (e): Discharge uncertainty
Annie	+	+	++	I	+
Leonard	+	NC	NC	++	NC
Grace	+	+	+	+	+
Beryl Clare	NC	++	++	++	++
Charles Betty	++	+	++	++	++
Kath Jane	+	++	+	++[ED]	++
Albert	+	+	+	++	++
David	+	NC	NC	NC	++
Ida	+	+	+	NC	NC
Doris	T	NC	+	+	NC
Norman	+	+	++	++	++
Barry	T	+	+	NC	NC
Malcolm	NC	NC	NC	NC	NC
Norma	T	NC	++	+	+[ED]
Edna	+	++	NC	+	NC
Freda Keith	+	NC	++	I	++
Jean Diane	NC	NC	NC	NC	NC
Jake Vera	NC	NC	++[ED]	++[ED]	+

Decision rule: Every quotation read in relation to each sub-theme and rated according to strength of comments made.

Legend: Strength of response:

+ Sub theme evident through participant comments

++ Displeasure evident through participant comments

NC= no comment made relevant to sub-theme

T= Participant spoke of treatment

I= Participant spoke of information provided by staff

ED= Emergency department

Summary:

Sub-theme (a): Perceived lack of treatment: Column 1 in the above table. Eleven participants spoke about a lack of treatment on the AMU. This was compared to just three participants who made a reference to receiving treatment. The participant comments suggested that they did not perceive they were treated on the AMU.

Sub-theme (b): Constant disturbance: Column 2 in the above table. Ten participants spoke about being constantly disturbed on the AMU, either by events occurring around them (6 participants) or by internal disturbances such as pain or discomfort (4 participants).

Sub-theme (c): Waiting: Column 3 in the above table. Twelve participants spoke about waiting on the AMU. Six of these participants made negative comments in relation to this waiting.

Sub-theme (d): Inadequate communication: Column 4 in the above table. Nine participants made comments in relation to inadequate communication by staff on the AMU. Five of these participants expressed displeasure about the level of staff communication. Only two participants provided any examples of staff communicating information to patients.

Sub-theme (e): Discharge uncertainty: Column 5 in the above table. Ten participants spoke about feeling uncertain about the time of discharge from the AMU. This uncertainty was either attributed to waiting around for hospital transportation, or due to a lack of information (or inconsistent information) provided by the staff on the AMU. Seven of the participants expressed displeasure in this respect about the discharge process.

Appendix 3 (c)

Staff Recognition Theme

Data Display Table

Participant ID	Theme 1: Incomplete Satisfaction	Theme 2: Staff Recognition	Decision rule: Every quotation read in theme and rated according to strength.
Annie	+	+++	
Leonard	+++	+++	
Grace	+	+++	
Beryl Clare (carer)	+++	NC	
Charles Betty (carer)	+++	NC	
Kath Jane (carer)	++(P)+(C)	+++ (C)+(P)	
Albert	++	+++	
David	+	+++	
Ida	+	+++	
Doris	+	+++	
Norman	++	++	
Barry	+	+++	
Malcolm	NC	+++	
Norma	+	+++	
Edna	++	+++	
Freda Keith (carer)	++	+++ (P) NC (C)	
Jean Diane (carer)	++ (C)+(P)	+++ (P) NC (C)	
Jake Vera (carer)	++ (C) NC (P)	+(P) NC (C)	

Legend: Strength of response:

Theme 1: Refer back to legend in appendix 3a

Theme 2:

+ Participant voiced that staff were quite good/care was nothing out of the ordinary/treated alright

++ Participant voiced that staff were good/attentive/efficient/ kind

+++ Participant voiced that staff were marvellous/very good/excellent
(The highest strength for each participant is recorded)

NC= no comment made relevant to theme

P = Patient participant

C = Carer participant

Summary: Column 2 in the above table. Overall the participants voiced positive comments about the care provided on the AMU. Fifteen participants provided very favourable opinions. There were two notable exceptions from Beryl and Charles, who spoke about an overall negative experience. Three carer participants (Vera, Keith, Diane) did not witness the care on the AMU and so could not make comments.

Appendix 3 (d)

Staff Recognition: Sub-theme: Dispersal of blame

Data Display Table

Participant ID	Sub-theme: Dispersal of Blame
Annie	+
Leonard	+
Grace	++
Beryl	++
Clare (carer)	++
Charles	NC
Betty (carer)	NC
Kath	+
Jane (carer)	+
Albert	++
David	++
Ida	+
Doris	+
Norman	++
Barry	++
Malcolm	NC
Norma	++
Edna	+
Freda	++
Keith (carer)	+
Jean	NC
Diane (carer)	NC
Jake	NC
Vera (carer)	NC

Decision rule: Every quotation in the sub-theme read and rated according to strength.

Legend: Strength of response:

+ Participant blamed one or more external factors for shortfalls in care delivery

++ Participant made excuses on the part of the staff. Did not want to proportion blame.

NC= no comment made relevant to the sub theme.

Summary: Fourteen patients and three carer participants blamed external factors for shortfalls experienced in respect of their care delivery. These factors were perceived as outside the remit of the staff delivering the care. Furthermore eight of these patients and one of the carers specifically made excuses on the part of the staff.

Appendix 3 (e)

Nebulous Grasp of Geriatrician Service

Data Display Table

Participant ID	Distribution and strength of theme	Decision rule: Every quotation read in relation to theme and assigned attributes accordingly.
Annie	+	Legend: Strength of response: + Participant identified geriatrician as pleasant/nice/good ++ Participant was able to outline the geriatrician intervention +++ Participant was aware that tests or treatment had been organised but was unsure if geriatrician was responsible ++++ Participant was unclear what geriatrician did for them (These attributes are not graded. Each individual attribute is recorded on the table). NR= No recall of geriatrician NC= No comment made in relation to theme
Leonard	++++	
Grace	+/++++	
Beryl	+++	
Clare (carer)	NC	
Charles	NC	
Betty (carer)	+/++++	
Kath	++++	
Jane (carer)		
Albert	++++	
David	+/++	
Ida	NR	
Doris	+/++++	
Norman	++++	
Barry	+/++++	
Malcolm	NR	
Norma	+/++	
Edna	+/++++	
Freda	+/++++	
Keith (carer)	+	
Jean	NR	
Diane (carer)	++++	
Jake	NR	
Vera (carer)		

Summary: All 18 patients were seen by the geriatrician, either on the AMU, or at home, or both. Eight patient participants and two carer participants spoke very favourably about the geriatrician, reporting that he/she was very good, or indeed charming. Four patient participants could not comment on the geriatrician as they had no recall of seeing the geriatrician either on the ward or at home (two of these participants, Ida and Jean, did not receive a follow up home visit and so it is perhaps not surprising that their recall was absent). No participants provided unfavourable or negative comments about the geriatricians.

However eight patient participants and two carer participants were unable to clearly verbalise what the geriatrician had done for them. Some participants stated the geriatrician had done nothing (Leonard, Grace and Norman). A further two participants (Beryl & Doris) did verbalise details of their intervention, but were a little uncertain if the geriatrician was responsible for organising this intervention. Only two of the 18 patient participants (David & Norma) could clearly articulate what intervention had been provided and who was responsible.

Appendix 3 (f)

On-going Needs Theme

Data Display Table

Participant ID	On-going Needs	<p>Decision rule: Every quotation read in relation to any on-going needs & rated according to strength.</p> <p>Legend: Strength of response: + Participant expressed concern about general health ++ Participant expressed concern about symptoms related to admission +++ Participant expressed difficulty with ADL/s but can manage independently or with aid ++++ Participant expressed difficulty with ADL/s. Needs help to complete the activity or the activity is completed by another Participants expressed a range of problems across their ADLs, & the greatest level of dependence is therefore recorded. NC= No comment made in relation to theme</p>
Annie	++/+++	
Leonard	++/++++	
Grace	+/++++	
Beryl	++++	
Charles	+/++++	
Kath	++/+++	
Albert	++++	
David	++/++++	
Ida	++/++++	
Doris	+/++++	
Norman	++/++++	
Barry	++++	
Malcolm	++/++++	
Norma	++/++++	
Edna	++++	
Freda	NC	
Jean	++/++++	
Jake	NC	

Summary: Nine patient participants expressed concerns about on-going symptoms which had been attributed to the cause of their AMU admission. Sixteen participants spoke about difficulties completing their ADLs. Fourteen of these participants needed assistance from others to complete these activities (although Barry and Norma only needed help with housework). Additionally, it can be speculated from therapy observation that a further two participants (Jake & Freda) would also need assistance from others; although it was not mentioned in the interviews. All the participants expressing on-going health issues also spoke about problems completing their ADLs.

Appendix 3 (g)

On-going Needs: Sub-themes: a) unresolved health issues, b) Unresolved daily living needs

Data Display Table 1

Participant ID	Sub-theme 4 (a): Unresolved health issues	Sub-theme 4 (b): Unresolved ADLs
Annie	++	+
Leonard	++	++
Grace	+	++
Beryl	NC	++
Charles	+	++
Kath	++	+
Albert	NC	++
David	++	++
Ida	++	++
Doris	+	++
Norman	++	++
Barry	NC	++
Malcolm	++	++
Norma	++	++
Edna	NC	++
Freda	NC	NC
Jean	++	++
Jake	NC	NC

Decision rule: Every quotation read where reference was made to an on-going concern or issue.

Legend: 4 (a): Unresolved health issues:

+ Participant expressed concern about general health

++ Participant expressed concern about symptoms related to admission

Legend: 4 (b): Unresolved ADLs:

+ Participant expressed difficulty with ADL/s but can manage independently or with an aid

++ Participant expressed difficulty with ADL/s. Needs help to complete the activity or the activity is completed by another
NC= no comment made relevant to theme

Summary:

4(a): Unresolved health issues: Twelve participants spoke of on-going health issues, and nine of these participants expressed concerns about on-going symptoms which had been directly attributed to the cause of their AMU admission.

Sub-theme 4 (b): Unresolved daily living needs: Sixteen participants spoke about difficulties completing their ADLs (although Barry & Norma only had difficulty with household cleaning, and both had a cleaner to complete this activity). Of the remaining participants, 12 needed help to complete their ADLs.

Appendix 3 (h)

On-going Needs: Sub-themes: c) Impact on informal carer, d) Value of independence

Data Display Table 2

Participant ID	Sub-theme: c): Impact on informal carer	Sub-theme d): Value of independence.	Decision rule: Every quotation selected where participant spoke about informal carer supporting them with ADLs, and/or their desire to complete ADL/s themselves.
Annie	++(spouse/children)	+++	
Leonard	+++ (children/grandchildren)	++	
Grace	++++ (spouse/children/neighbour)	+	
Beryl	+++ (children)	+	
Charles	++++ (spouse)	++	
Kath	+++ (children)	+	
Albert	++++ (spouse)	++	
David	++++ (spouse)	++	
Ida	+++ (children)	++	
Doris	++ (children)	+	
Norman	NC (No informal carers)	NC	
Barry	+	+++	
Malcolm	NC (Residential care)	++	
Norma	+	+++	
Edna	+++ (children/grandchildren)	+	
Freda	NC (Bedbound)	NC	
Jean	+++ (children)	+++	
Jake	NC (Wife likely to have completed domestic ADLs)	NC	

Legend: c): Impact on informal carer

+ No help from informal carers

++ Informal carers provide support to engage in activities (rather than completing the activity for the patient)

+++ Informal carers complete domestic activities for the patient

++++ Informal carers assist with personal care & complete the domestic activities

Legend: d): Value of independence

+ Mild desire to complete ADLs (only an occasional or aside reference to complete an ADL)

++ Moderate desire to complete ADLs (clearly expresses a desire to complete/continue at least one ADL)

+++ Strong desire to complete ADL (specifically states a wish to be independent with ADLs)

NC= no comment made relevant to theme

Summary:

Sub-theme: c): Impact on informal carer: Thirteen participants spoke about the support provided by informal carers (this includes Malcolm, who although in a residential home, spoke about his daughter taking him on outings). In the interviews patients mainly spoke of informal carers supporting them with shopping and household cleaning. A further five patients were supported by their spouses, who were elderly themselves. All but one of these patients was supported with personal care activities. Two of these patients (David and Charles) spoke about the heavy demands of the carer role.

Sub-theme: d): Value of independence: Fifteen of the patient participants spoke about a desire to complete their own ADLs, compared to three patients who made no mention of any desire to complete their own ADLs. The strength of desire varied across patients, from those who only make an occasional reference to completing an ADL themselves (and perhaps would be quite happy for others to complete the activities), to those who specifically stated that they wished to be independent with ADLs. The desire to complete some ADLs (rather than others completing these activities for them) was evident amongst 10 of the patients. Whilst four patients strongly expressed a desire to be independent with their ADLs, the data suggests that overall the patients did wish to complete their own ADLs.

Appendix 3 (i)

Stoicism Theme

Data Display Table

Participant ID	Theme 5
Annie	+ / + + / + + +
Leonard	+ / + + / + + +
Grace	+ / + + / + + +
Beryl	+ / + + / + + +
Clare (carer)	+ / + + / + + +
Charles	+ + +
Betty (carer)	+ + +
Kath	+ + / + + +
Jane(carer)	+ + / + + +
Albert	+ / + + / + + +
David	+ / + + / + + +
Ida	+ / + + / + + +
Doris	+ / + + / + + +
Norman	+ / + + / + + +
Barry	+ / + + / + + +
Malcolm	+ / + +
Norma	+ / + + / + + +
Edna	+ / + + / + + +
Freda	+ + / + + +
Keith (carer)	+ + +
Jean	+ / + +
Diane (carer)	NC
Jake	+ +
Vera (carer)	+ / + + +

Decision rules: Every quotation read in relation to theme & rated according to strength.

Legend:

+ Participant voiced an assumption around generalised problems in the NHS
 ++ Participant made excuses for the situation or voiced acceptance of the situation
 +++ Participant expressed tolerance around weaknesses with care/treatment
 (These attributes are not graded. Each individual attribute is recorded on the table)
 NC = no comment made relevant to theme

Summary: Fifteen of the patient participants and five of the carer participants voiced tolerance around weaknesses experienced on the AMU. The outliers provided muddled accounts and struggled to recall the AMU admission. All but one of the patient participants provided explanations, outside the remit of staff, to explain away the shortfalls.

Appendix 3 (j)

Stoicism Sub-themes

Data Display Table

ID	Sub-theme (a): Ageing assumptions	Sub-theme (b): Modest expectations	Sub-theme (c): Minimized needs	Sub-theme (d): Passive acceptance
Annie	+	+	++	+
Leonard	+	+	NC	+
Grace	++	+	++	+
Beryl	NC	NC	NC	+
Clare (Carer)	NC	+	NC	+
Charles	NC	NC	NC	+
Betty (Carer)	+	NC	NC	+
Kath	NC	+	++	NC
Jane (Carer)	NC	NC	NC	NC
Albert	+	+	++	+
David	++	+	++	+
Ida	++	+	+	NC
Doris	+	+	NC	+
Norman	NC	+	NC	+
Barry	NC	+	+	NC
Malcolm	+	NC	NC	+
Norma	++	+	+	+
Edna	++	+	NC	NC
Freda	NC	+	++	NC
Keith (Carer)	NC	+	NC	NC
Jean	+	+	NC	+
Diane (Carer)	NC	NC	NC	NC
Jake	NC	+	NC	NC
Vera (Carer)	NC	NC	+	NC

Decision rule: Every quotation read in relation to each sub-theme and rated (if appropriate) according to strength.

Legend: Strength of response:

Sub themes (a) – (d):

+ Sub-theme evident through participant comments

Sub-themes a & c are graded as follows:

Sub-theme (a):

++ Expectation that ageing linked to decline in health and functional ability

Sub-theme (c):

++ Recognition that other patients in greater need

NC = no comment made relevant to theme

Summary:

Sub-theme (a): Ageing assumptions: Twelve of the patient participants and one of the carer participants showed recognition that they were ageing. Five of these expected to become ill and/or disabled as a result of the ageing process.

Sub-theme (b): Modest expectations: Fifteen of the patient participants and two of the carer participants quotations suggest modest, if not low, expectations in respect of the care/treatment they could realistically receive in the acute hospital setting.

Sub-theme (c): Minimized needs: Nine patient participants and one of the carer participants minimized their needs, and six of these participants recognised there were other patients in greater need of attention than themselves. They felt attention should be prioritised to those in greatest need.

Sub-theme (d): Passive acceptance: Twelve patient participants and two of the carer participants revealed a passive acceptance towards their care and treatment. These participants did not question or challenge the AMU staff.